

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

1264

1250

1264

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>23X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Adkins</u> Last <u>Adkins</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 17-1961</u>
9. AGE (In years last birthday) yrs. <u>2</u> Months <u>3</u> Days <u>39</u> Min.		10. IF UNDER 1 YEAR <u>2</u> IF UNDER 24 HRS. <u>39</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, md</u>	
11. BIRTH PLACE (State or foreign country) <u>Salisbury, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Merrill Thomas Adkins</u>		14. MOTHER'S MAIDEN NAME <u>Adna E. McYall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>M. Thomas Adkins, Snow Hill, md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Maternal Antenatal Bleeding</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/17</u> 19 <u>61</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Alfred C. Kells</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Medical Center, Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Buried Jan 17/61</u>		23b. NAME OF CEMETERY OR CREMATORY <u>Union Baptist Cemetery</u>	
23c. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>		23d. REC'D BY REGISTRAR <u>JAN 23 '61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wiley E. Dennis</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2042353XV2

Attest
My hand and seal of office
this 1st day of January
1885 at Austin, Texas

Mayor of Antelope, B. O. ...

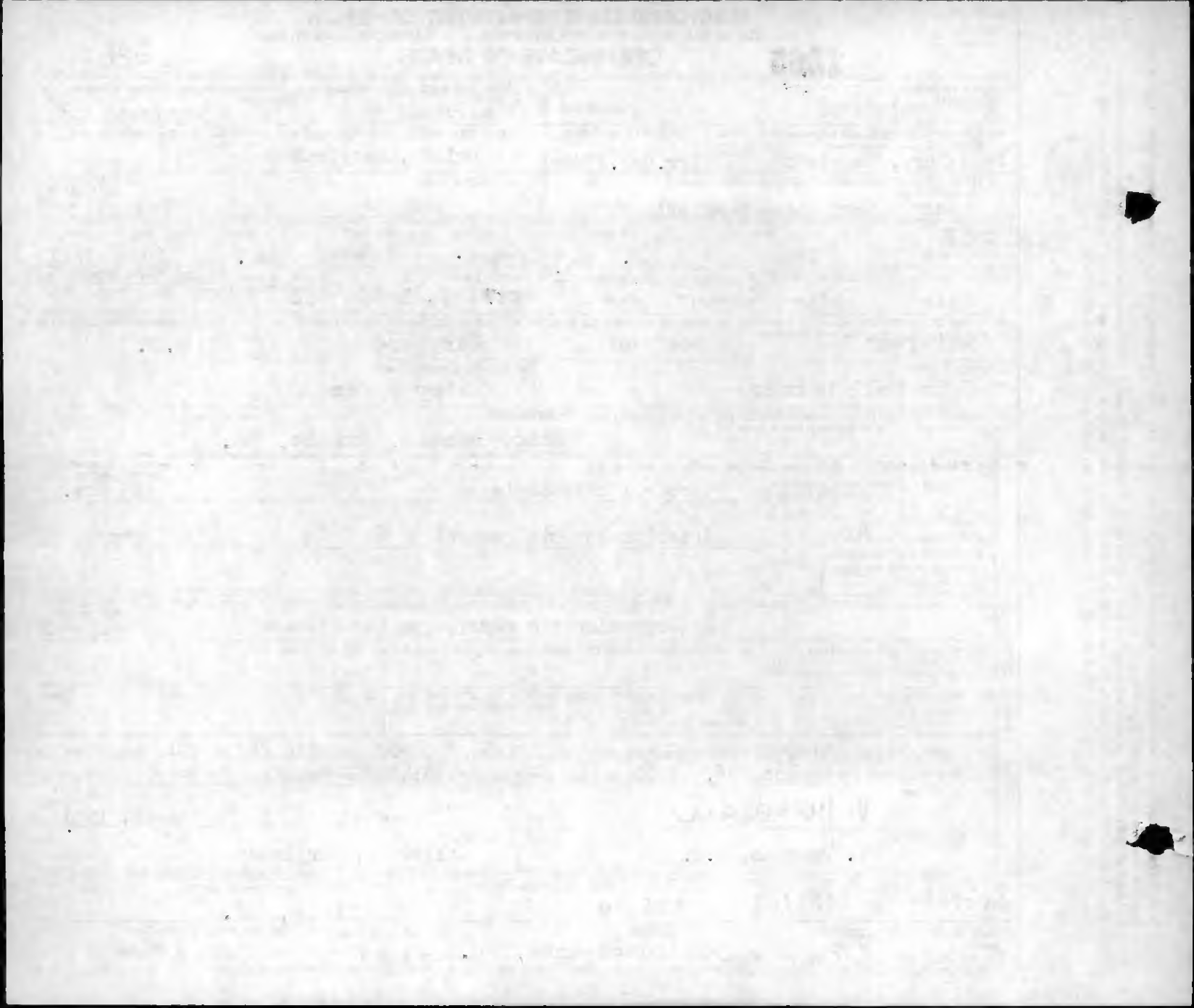
Witness my hand and seal of office
this 1st day of January
1885 at Austin, Texas

Attest
My hand and seal of office
this 1st day of January
1885 at Austin, Texas

CERTIFICATE OF DEATH

0125

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 1yr. 8mo. 23days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer s Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 19 X-2		3. NAME OF DECEASED (Type or print) First John Middle R. Last Bozman		4. DATE OF DEATH Month Jan. Day 28 Year 19 61	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2, 1885		9. AGE (In years last birthday) yrs. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY seafood		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME John Bell Bozman				14. MOTHER'S MAIDEN NAME Maley Jones				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Brice Bozman, Oriole, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis general DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 15 hrs. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from May 5, 1959 , to Jan 28, 1961 , that (I) (we) lost the deceased alive on Jan 28, 1961 , and that death occurred at 8:45 PM from the causes and on the date stated above.									
22a. SIGNATURE V. Juerman				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED Jan 29, 1961	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.				22d. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE THEREOF 1/31/61		23c. NAME OF CEMETERY OR CREMATORY Oriole		23d. LOCATION (City, town, or county)		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE James Juerman		ADDRESS Princess Anne, Md.		25a. REC'D BY REGISTRAR DATE FEB 7 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Knead			



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VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1266

1252

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Georgia Middle Brenner Last Brenner		4. DATE OF DEATH Month January Day 26 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-1884
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robt Kenna		14. MOTHER'S MAIDEN NAME Maetha Kenna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs Georgia Carter		Address Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Arteriosclerosis, general Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general DUE TO (c) Arteriosclerosis, general		INTERVAL BETWEEN ONSET AND DEATH Yrs Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old cerebral thrombosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 12 19 61 , to Jan. 26 19 61 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 12:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve, M. D.		22b. DATE SIGNED 1/26/61	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-29-61	
23c. NAME OF CEMETERY OR CREMATORY Perryhawkin cem.		23d. LOCATION (City, town, or county) (State) Near Princess Anne, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson		25a. REC'D BY REGISTRAR Princess Anne, Md. DATE FEB 1 '61	
25b. REGISTRAR'S SIGNATURE Charles S. House			

1. The first part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into two columns, with names on the left and dates on the right.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1267

61253

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Pocomoke City</u>			
c. LENGTH OF STAY IN 1b <u>10 HOURS</u>				d. STREET ADDRESS <u>R.F.D. 1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LUTHER S. Brittingham</u>			4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1961</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 16, 1905</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>CHARLES L. BRITTINGHAM</u>				14. MOTHER'S MAIDEN NAME <u>EMMA R. RITCHIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WW #2 215-16-8394</u>		17. INFORMANT <u>MRS CLARENCE J. TAYLOR, Pocomoke City, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct, acute</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-10-1961</u> to <u>1-10-1961</u> , that (I) (we) last saw the deceased alive on <u>1-10-1961</u> , and that death occurred at <u> </u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. R. Ellis, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-10-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. R. ELLIS, JR. M.D.</u>				22d. ADDRESS <u>SALISBURY, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-13-61</u>		23c. NAME OF CEMETERY <u>GOODWILL METHODIST</u>		23d. LOCATION (City, town, or county) (State) <u>RURAL - Pocomoke City MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>				ADDRESS <u>Pocomoke City, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 16 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

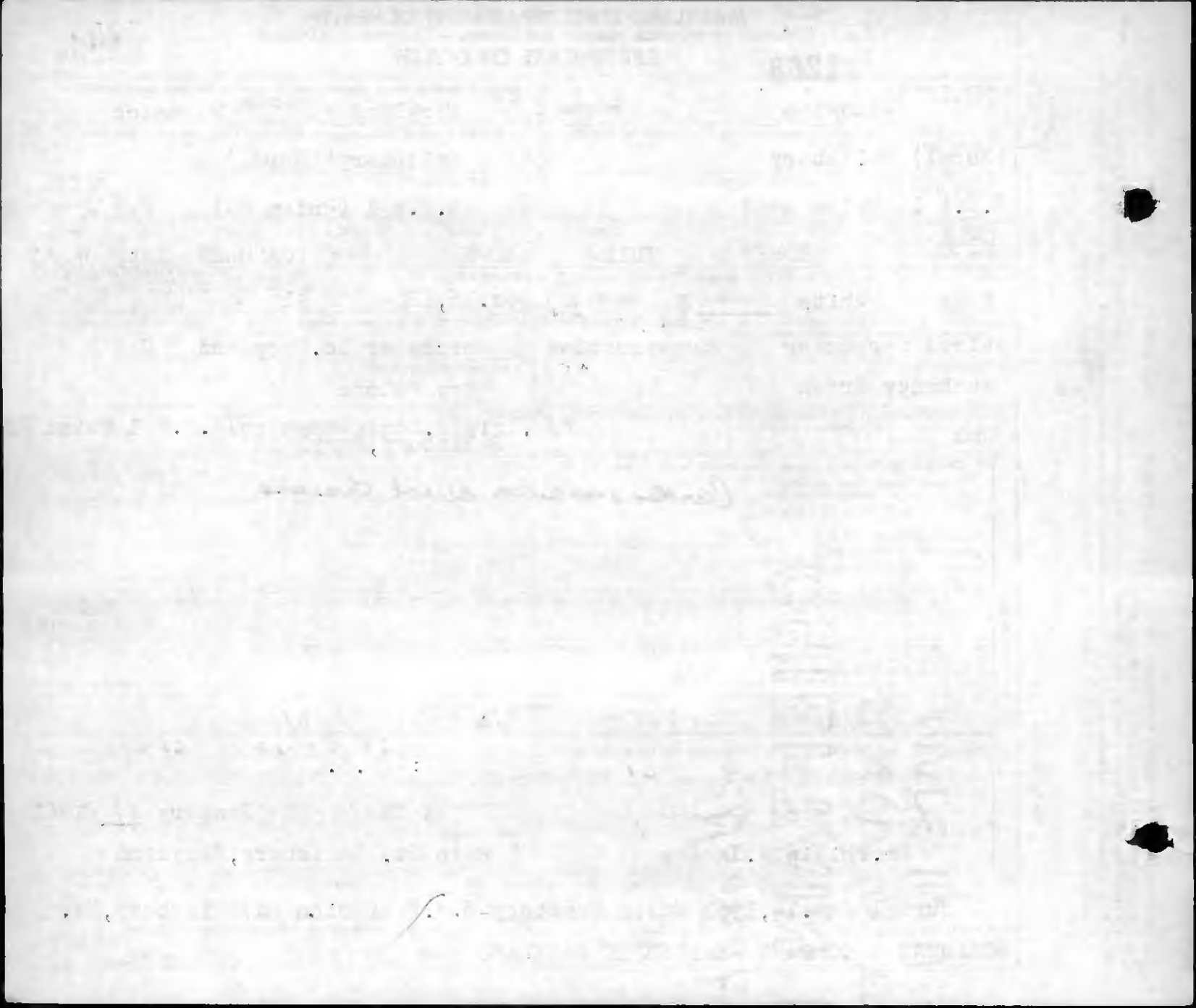
VR A15 (4)
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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

61254

1268

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1 Union Road				d. STREET ADDRESS R.D.# 1 (Union Rd)			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SYDNEY Middle TULL Last BROWN				4. DATE OF DEATH Month JANUARY Day 10th Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1869	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Anthony Brown				14. MOTHER'S MAIDEN NAME Mary Malone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Iris B. Long (Daughter) Address R.D.# 1 Union Rd Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 442x IMMEDIATE CAUSE (a) Cardiovascular renal disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 1958 to 1-10-1961 , that (I) (we) last saw the deceased alive on 1-9-1961 , and that death occurred at 1:20 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Philip A. Insley				22b. DATE January 11/1961		22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley	
22d. ADDRESS Main St. Salisbury, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 14, 1961		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery-R.D.# 1 (Union Rd) Salisbury, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE JAN 13 '61	
				25b. REGISTRAR'S SIGNATURE Charles E. Hines			



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1269

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

(125)

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron (Rural)			
				d. STREET ADDRESS R.D.# 1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First NORMAN Middle LEE Last BRUMLEY				4. DATE OF DEATH Month JANUARY Day 5th Year 1961			
5 SEX Male	6 COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 19, 1908		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed (J.H. Dulany Foods Inc) Supv.				10b. KIND OF BUSINESS OR INDUSTRY Eden, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Glenmore Franklin Brumley				14. MOTHER'S MAIDEN NAME Annie Carey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Informant			
				17. ADDRESS Mrs. Lucille G. Brumley (Wife) R.D.#1 Hebron, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma left lung DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. N/A 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	
				20f. (City or town) N/A		(County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 10/8/54 to 1/5/61 , 19____, that (I) (we) last saw the deceased alive on 1/5/61 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Andrew C. Mitchell				22b. DATE Jan. 6 /1961			
22c. PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell				22d. ADDRESS Maryland Ave. Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 8, 1961		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE JAN 9 '61	
				25b. REGISTRAR'S SIGNATURE C. S. Hanna			



FOR STATE
HEALTH DEPT.

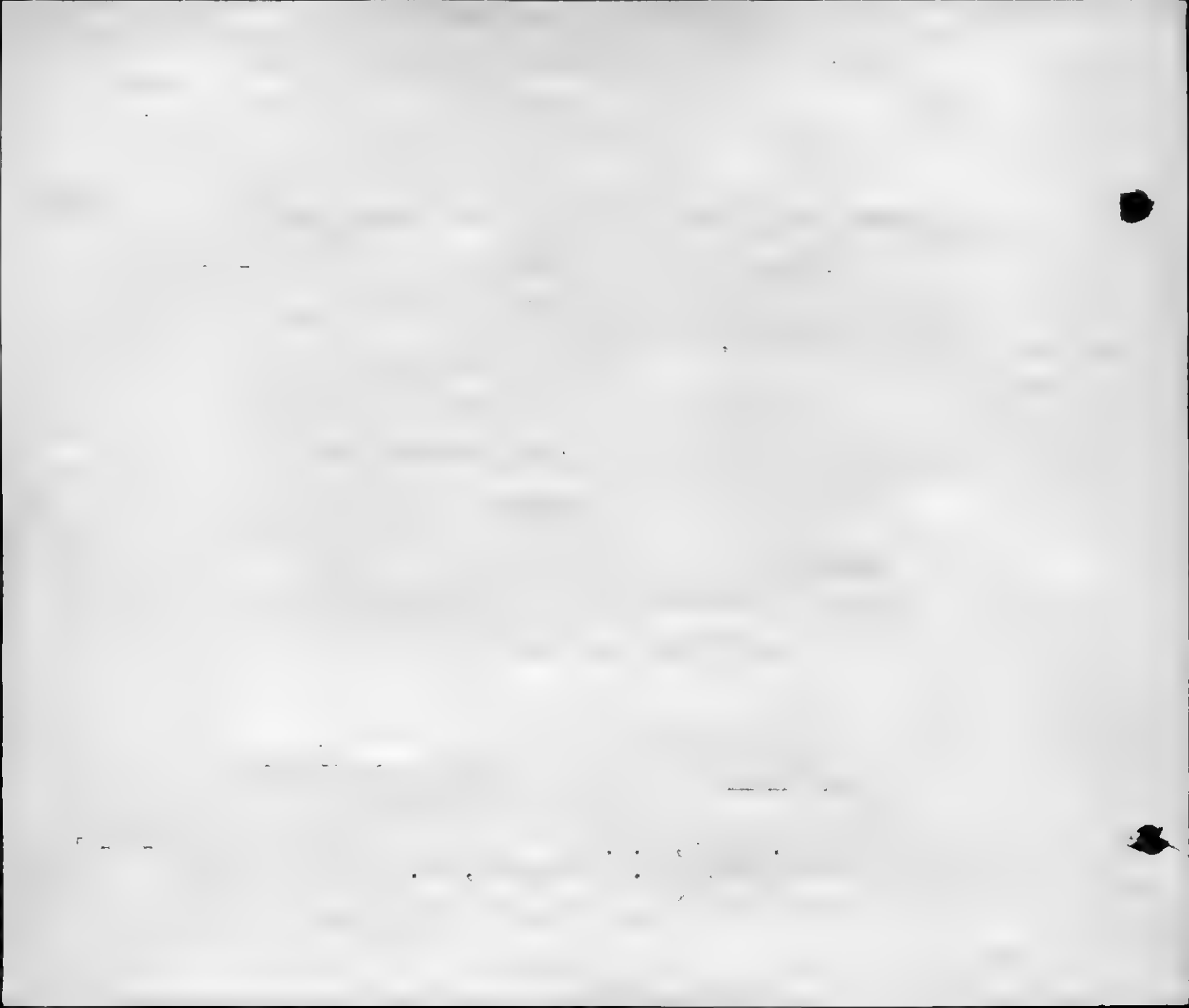
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1270 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64250

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 16 Newport Acres	
3. NAME OF DECEASED (Type or print) Michael Bryant	4. DATE OF DEATH 1-26-61	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-8-1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M		11. BIRTHPLACE (State or foreign country) Maryland	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
3. FATHER'S NAME Calvin Barckley		14. MOTHER'S MAIDEN NAME Doris Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or details of service)		17. INFORMANT Doris Williams, Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningococcemia C. 7.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED: 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF 1-29-61		DATE SIGNED 1-27-61	
22c. NAME OF CEMETERY OR CREMATORY GREEN ACRES Cem		22d. LOCATION (City, town, or county) (State) Salisbury Md.	
23. FUNERAL DIRECTOR Thornton B. Bolley, Salisbury, Md.		24a. REC'D BY REGISTRAR DATE JAN 31 '61	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hays	



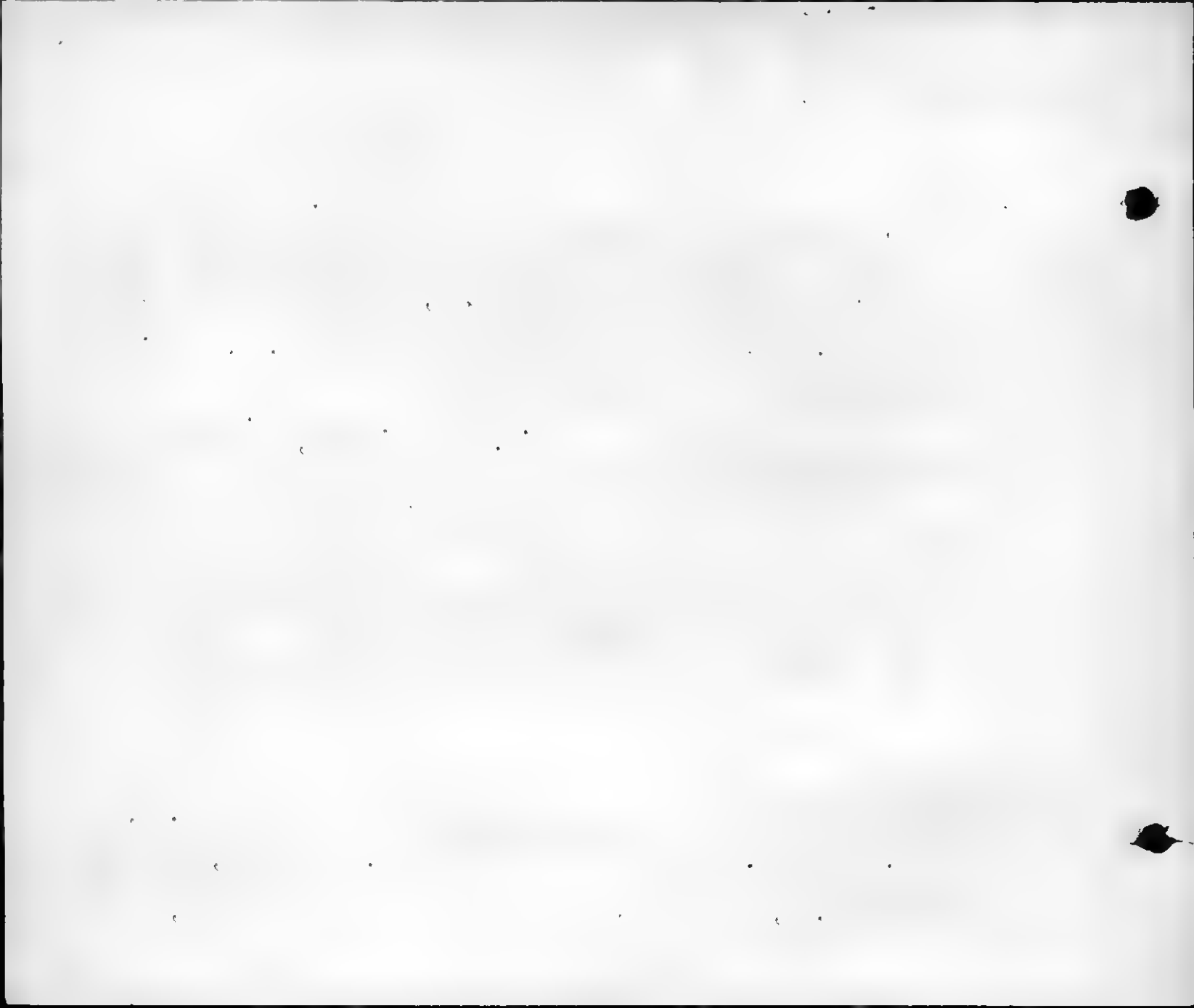
(M)

1271

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

(125)

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Finis Suba General</u>				d. STREET ADDRESS <u>330 Camden Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>John Thomas Burkhardt</u>				4. DATE OF DEATH <u>January 10 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR <u>3</u> Months <u>25</u> Days		IF UNDER 24 HRS. <u>10</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee (Wico. Hotel)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Interior Decorator - Baltimore Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles Burkhardt</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth (No Record)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>N/A</u>			
17. INFORMANT <u>Mrs. Estelle M. Burkhardt (Wife)</u>				18. ADDRESS <u>330 Camden Ave. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Epidemioid CA of Lung</u>							
163X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour o m. <u>N/A</u> 19 <u>61</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>	
				20f. (City or town) <u>N/A</u> (County) <u>N/A</u> (State) <u>N/A</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 9, 1961</u> to <u>Jan. 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan. 9, 1961</u> , and that death occurred at <u>5:38 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>William D. Gray</u>				M D ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Jan. 10, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>				22d. ADDRESS <u>Camden Ave. Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 12, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL MEMORY GARDENS - Salisbury, Maryland</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				25a. REC'D BY REGISTRAR <u>JAN 13 '61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>(Signature)</u>	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1258

1272

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Quantico				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Quantico (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#				d. STREET ADDRESS R.D.#			
3 NAME OF DECEASED (Type or print) First Middle Last ROBERT GREENSBURY BYRD				4 DATE OF DEATH Month Day Year JANUARY 17th 19 61			
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1879		9 AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 8 14	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) R.D.# Quantico, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Francis Byrd				14. MOTHER'S MAIDEN NAME Rachel Owens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Mr. Lee C. Byrd (Son) R.D.# Quantico, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subacute cystopyelonephritis 610 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertrophy of prostate gland with urine retention DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic encephalopathy and coronary						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Cholera					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. N/A 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21 I certify that (I) (this hospital) attended the deceased from Jan 10 1961 to Jan 17 1961 , that (I) (we) last saw the deceased alive on Jan 10 1961 , and that death occurred at 4:05 A.M. from the causes and on the date stated above.							
22a. SIGNATURE L.V. Sohler				22b. DATE SIGNED Jan. 19, 1961		22c. PHYSICIAN'S NAME (Type) Dr. L.V. Sohler	
22d. ADDRESS Delmar, Maryland							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 19, 1961		23c. NAME OF CEMETERY OR CREMATORY PARSONS CEMTERY		23d. LOCATION (City, town, or county) (State) SALISBURY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR JAN 23 61	
				25b. REGISTRAR'S SIGNATURE Wm. D. H. H.			



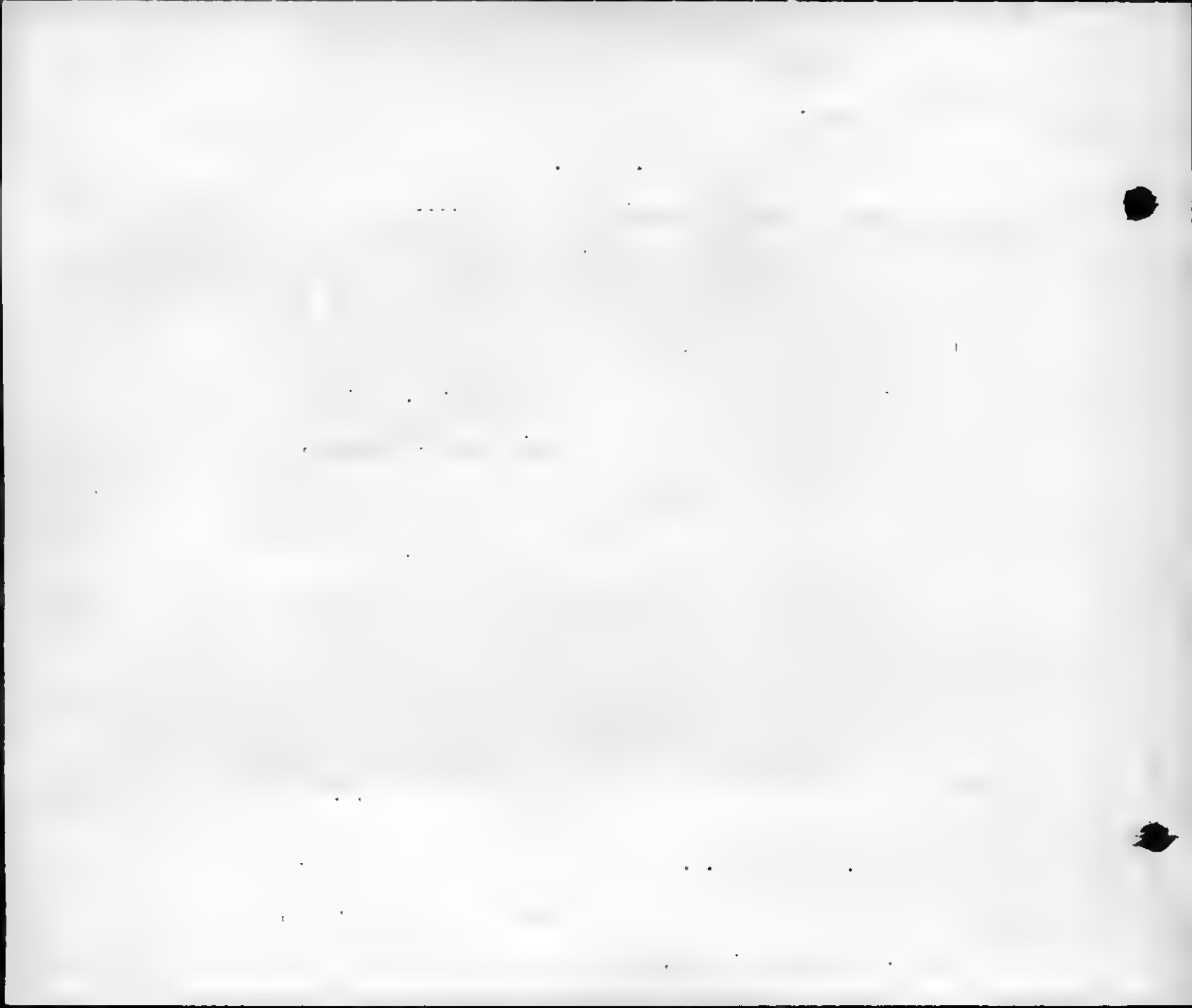
1
 TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed to the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1273
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02460

1 PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 1 mo. 20 da. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico d. STREET ADDRESS ---- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Alma Middle Naomi Last Camper		4. DATE OF DEATH Month January Day 31 Year 19 61	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/2/1906
9. AGE (In years last birthday) 54 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't Dietian	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Perry Wright		14. MOTHER'S MAIDEN NAME Sarah J. Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT David Camper, Quantico, Md RT #1		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breasts w/metastases to Chest 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 Years
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 12/12/60 19 to 1/31/61 19, that (I) (we) last saw the deceased alive on 1/31/61 19, and that death occurred at 5: M. from the causes and on the date stated above			
22a SIGNATURE V. Juerman 22c PHYSICIAN'S NAME (Type) V. Juerman, M.D.		22b. DATE SIGNED 1:55 P.M. 22d. ADDRESS Deer's Head State Hospital Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/5/61	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cem	23d. LOCATION (City, town, or county) (State) Weptquin, Md
24. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley		25a REC'D BY REGISTRAR FEB 8 '61 25b REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1274

1259

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>2 WKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>				e. STREET ADDRESS <u>1 Johnson Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>ANN</u> Last <u>Chatham</u>				4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 2, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Alec B. Malone</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>C. HERBERT CHATHAM, SAME</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>443 X</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause (a). (b) <u>Hypertensive C.V. Disease</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>17 days</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , 19 <u> </u> , to <u>1152w</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11 Jan 1961</u> and that death occurred on <u>12 Jan 1961</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Earl A. Royer</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>1-11-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Earl A. Royer</u>				22d. ADDRESS <u>407 Camden Ave. Sal. Md.</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-13-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co.</u>				ADDRESS <u>Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
				DATE <u>JAN 16 '61</u>			

King C. Peck



FOR STATE
HEALTH DEPT.

TO REGISTER: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT5ME
SM 7/59

MEDICAL CERTIFICATION

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

23. FUNERAL DIRECTOR

Burial

Earl L. Royer, M.D.

407 Camden Ave. Salisbury, Md.

22b. DATE THEREOF

2-2-61

22c. NAME OF CEMETERY OR PLACE OF BURIAL

First Baptist

Pocomoke City, Md.

24a. REC'D BY REGISTRAR

DATE FEB 6 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kross

13. FATHER'S NAME

Arie James Taylor

14. MOTHER'S MAIDEN NAME

Pearl Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.

218-20-7766

17. INFORMANT

Mrs Arie J. Taylor, Pocomoke City, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Broncho-pneumonia: Peritonitis.

INTERVAL BETWEEN
ONSET AND DEATH

13 days

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Bullet wounds of left chest & abdomen

13 days

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Shot by R. L. Parker

20c. TIME OF INJURY

Hour a.m.

11:30 P.M.

Month, Day, Year

1-17-61

20d. INJURY OCCURRED

While Not While

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Street

20f. (City or town)

Pocomoke Worcester Md.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

CHIEF MEDICAL EXAMINER

ASS STANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

2-1-61

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

2-2-61

22c. NAME OF CEMETERY OR PLACE OF BURIAL

First Baptist

22d. LOCATION (City, town, or country)

Pocomoke City, Maryland

(State)

1. PLACE OF DEATH

a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN 1b

12 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Peninsula General Hospital

3. NAME OF DECEASED
(Type or print)

Rena Mae Taylor Choquette

5. SEX

F

W

6. COLOR OR RACE

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

May 18, 1927

9. AGE (In years last birthday)

33 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

4. DATE OF DEATH

1-30-61

19

Last

Month

Day

Year

d. STREET ADDRESS

814 Second St.

Pocomoke City

Maryland

b. COUNTY

Worcester

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

e. IS RESIDENCE ON A FARM?

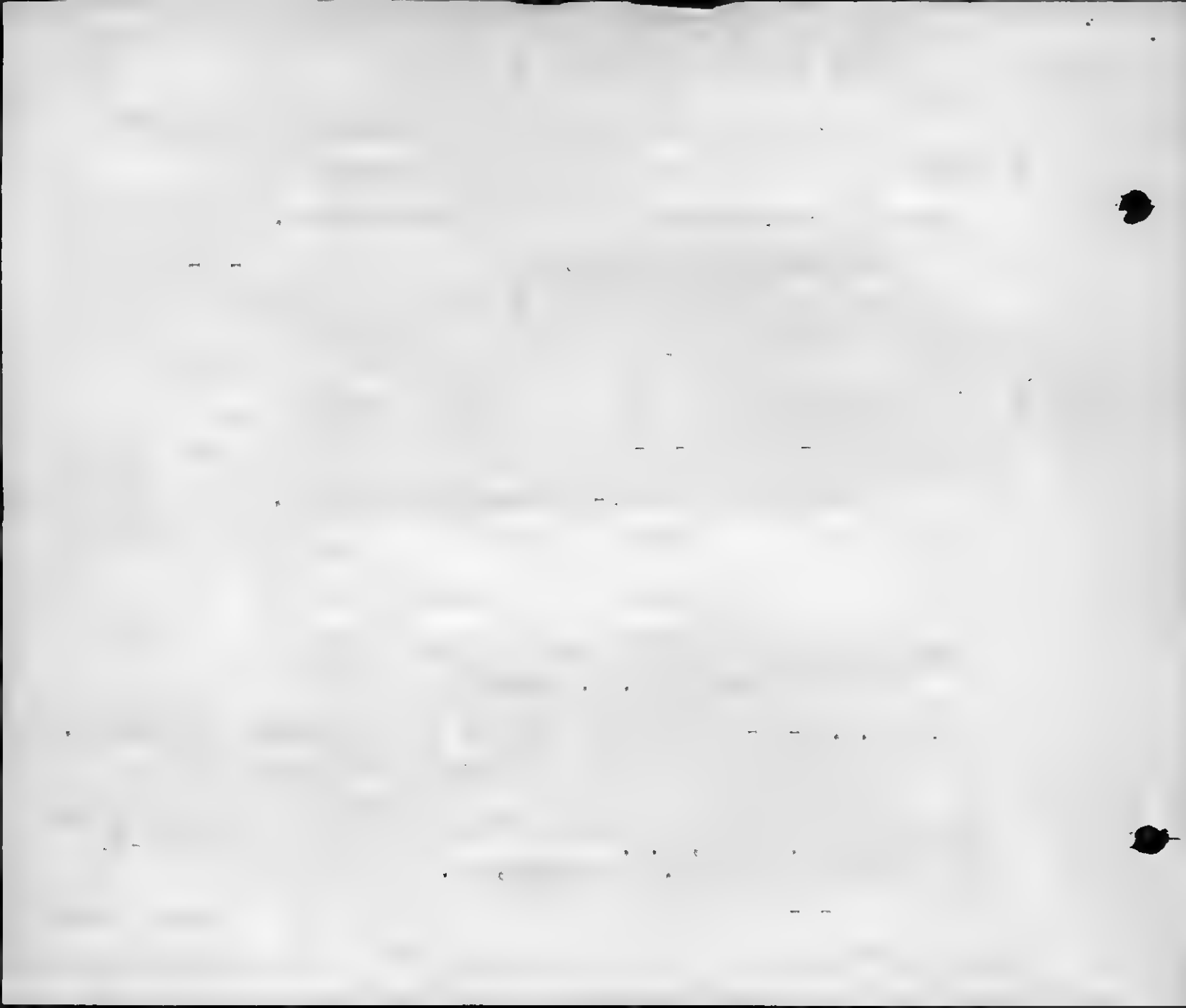
YES ☐ NO ☒

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1260

MARYLAND STATE DEPARTMENT OF HEALTH



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1276

1261

Item 14 File 6281 2-14-61 et

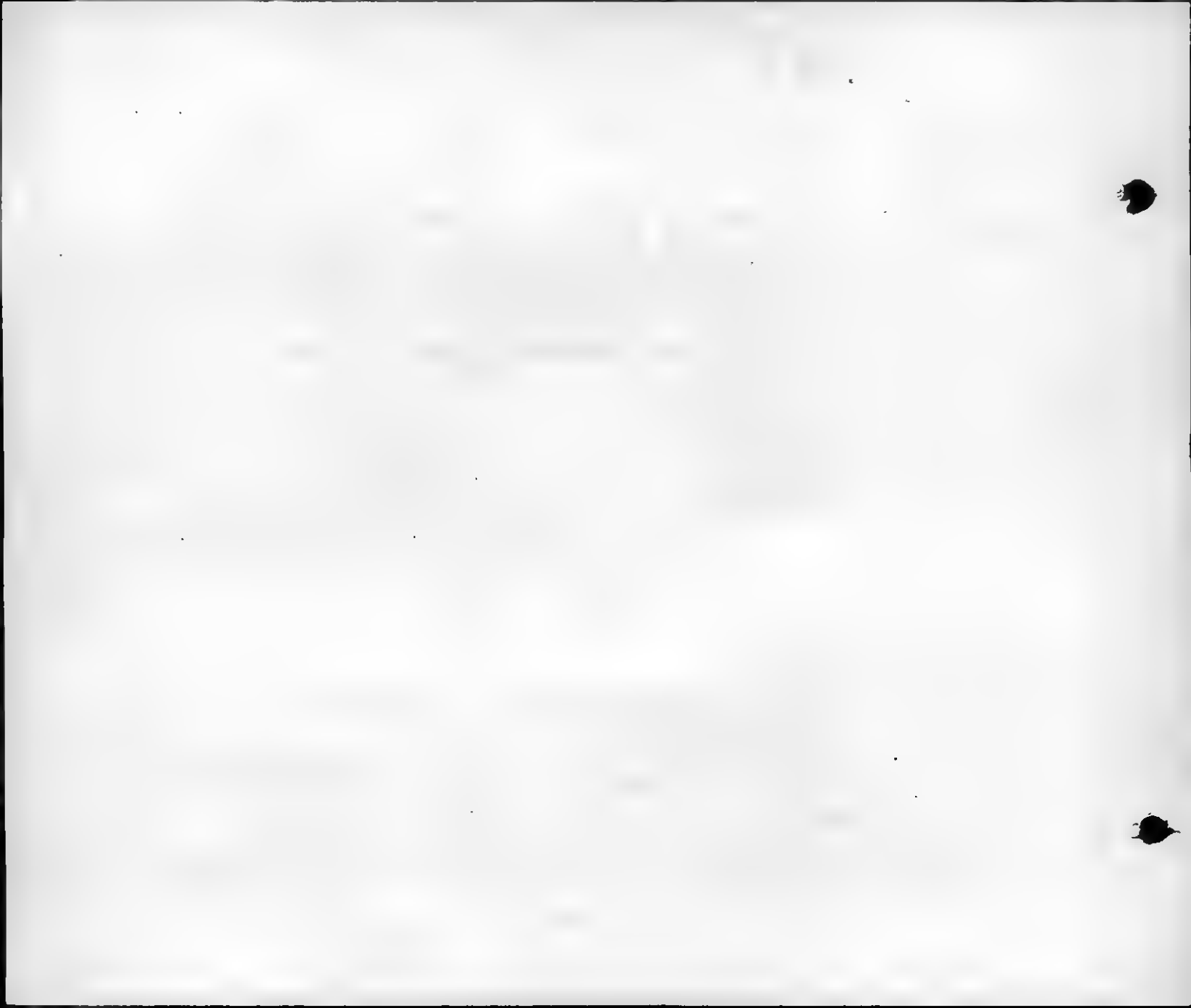
1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE MD. b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BELLEVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PEN. GENERAL HOSPITAL		d. STREET ADDRESS BAY ST	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS CORNELIUS Coffin		4. DATE OF DEATH Month Day Year JAN. 31 1961	
5. SEX M	6. CO. OR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1881
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCKER		10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS	
11. BIRTHPLACE (State or foreign country) BERLIN, MD (RFD)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS T. COFFIN		14. MOTHER'S MAIDEN NAME Cora Trader	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Atherosclerotic Cardiovascular Disease lying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary Tract infection			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-16-1961 to 1-31-1961 that (I) (we) last saw the deceased alive on 1-31-1961 and that death occurred at 2:00 P.M. from the causes and on the date stated above			
22a. SIGNATURE Robert Thomas		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Annina A. Burbage		22d. ADDRESS Berlin Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/3/61	23c. NAME OF CEMETERY OR CREMATORY TAYLORVILLE	23d. LOCATION (City, town, or county) (State) BERLIN MD
24. FUNERAL DIRECTOR'S SIGNATURE Annina A. Burbage		25a. REC'D BY REGISTRAR DATE FEB 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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6

MEDICAL CERTIFICATION



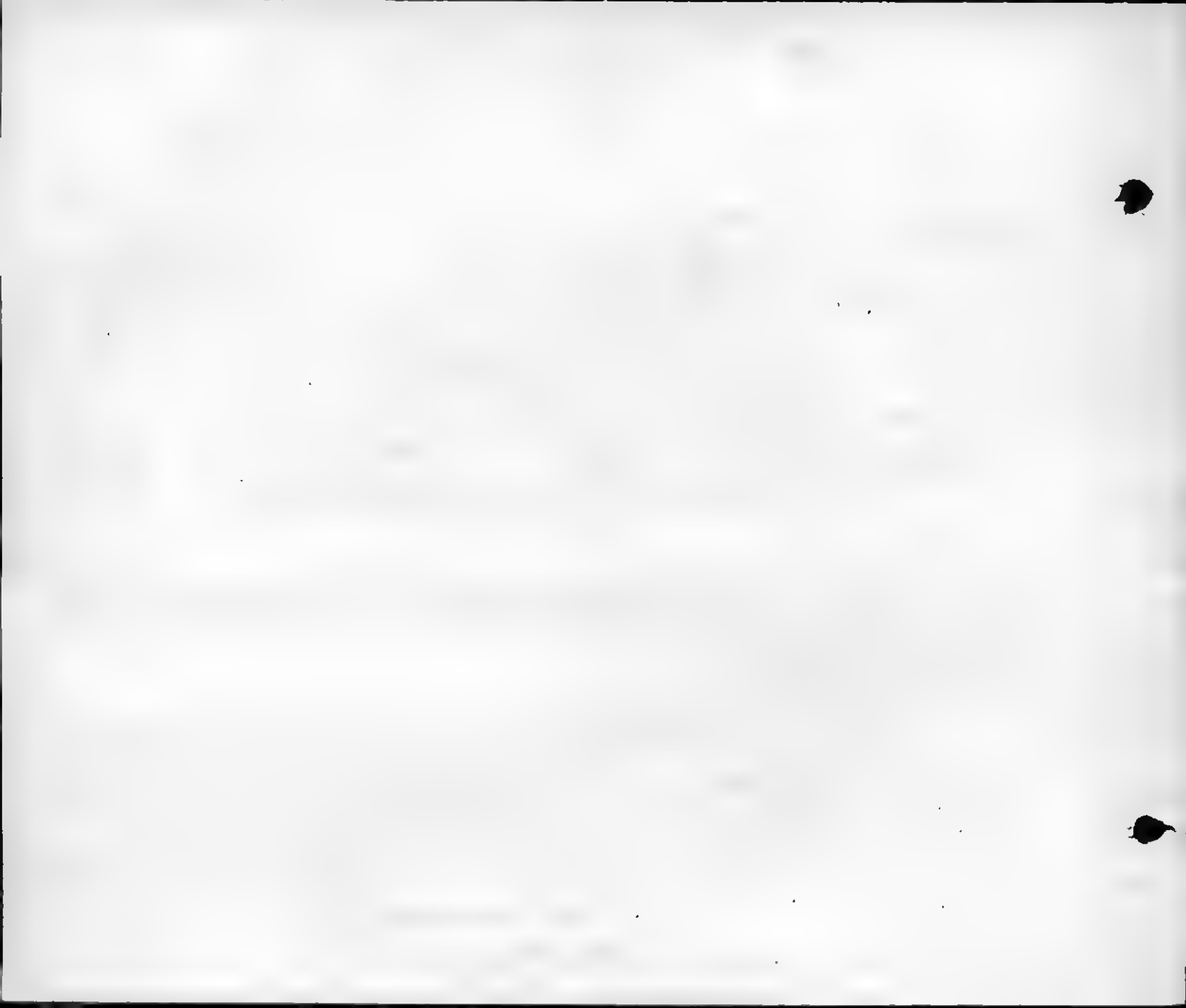
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1277
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1262

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ACCOMAC</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague, Virginia</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>102 Ocean Blvd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LYDIA MAE COLLINS</u>		4. DATE OF DEATH Month Day Year <u>1 29 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 9 1900</u>
9. AGE (In years last birthday) yrs <u>60</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>CHINCOTEAGUE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John POINTER</u>		14. MOTHER'S MAIDEN NAME <u>DORA Wimbrow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Harry Collins Jr. Chincoteague, Virginia</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pneumococcal meningitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/29 1961</u> to <u>1/29 1961</u> , that (I) (we) last saw the deceased alive on <u>1/29 1961</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>David J. Gilmore</u>		22b. DATE SIGNED <u>1/29 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>—</u>		22d. ADDRESS <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-4-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SANCTIFIED Church CEM</u>		23d. LOCATION (City, town, or county) (State) <u>PERRY GA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Selpe, Chincoteague, Va.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 3 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



41263

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY <u>WICCONICO</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN <u>MD</u> <u>43 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u> d. STREET ADDRESS <u>20X-2</u>	
3. NAME OF DECEASED (Type or print) <u>Charles T. Cottingham</u>		4. DATE OF DEATH Month <u>January</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. B. DATE OF BIRTH <u>SEPT-1-1884</u>		9. AGE (In years last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Talbot County, Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN-W-COTTINGHAM</u>		14. MOTHER'S MAIDEN NAME <u>IDA CORKRAM</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>220-32-1022</u>		16. SOCIAL SECURITY NO. <u>220-32-1022</u>	
17. INFORMANT <u>Wm Cottingham</u>		Address <u>Oxford Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>181.0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>LEE L. LAURY</u> (this hospital) attended the deceased from <u>6 December, 1960, to 18 January, 1961</u> that (1) <u>Yes</u> last saw the deceased alive on <u>10 January 1961</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Lee L. Laury</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>LEE L. LAURY, M.D.</u>		22d. ADDRESS <u>Salisbury, Maryland</u> <u>Deer's Head State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 29, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Oxford Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm E. Newman & Son</u>		25a. REC'D BY REGISTRAR <u>JAN 23 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>C. E. Newman</u>		25c. REGISTRAR'S SIGNATURE	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

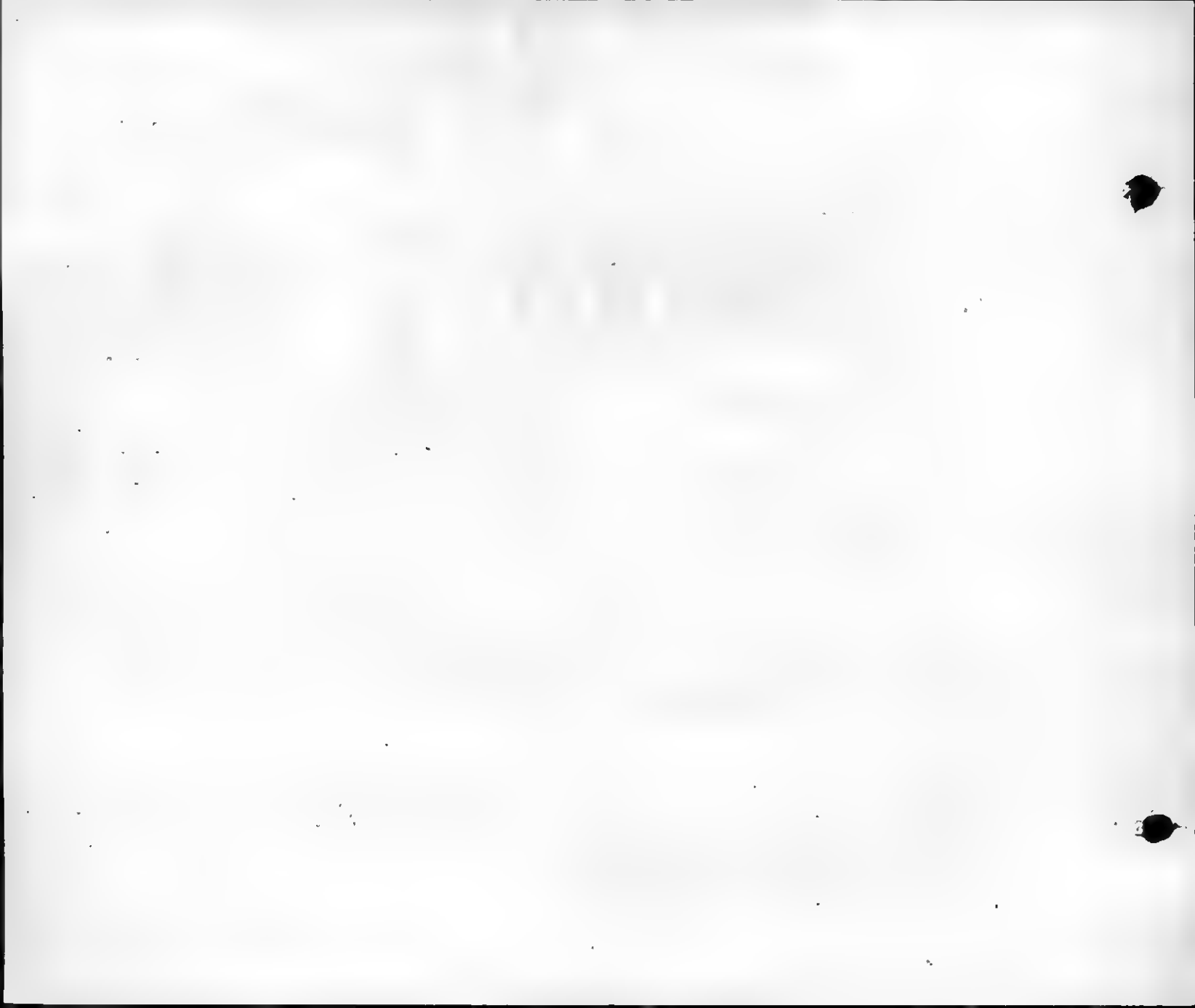
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1279

CERTIFICATE OF DEATH

Reg. Dist. No. 1264

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. # 1</u>				d. STREET ADDRESS <u>R.F.D. # 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Phoebe</u> Middle <u>E.</u> Last <u>Cottman</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1863</u>	9. AGE (In years last birthday) <u>97</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Cathell</u>				14. MOTHER'S MAIDEN NAME <u>Jane Cathell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u> </u>		INFORMANT <u>Littleton Cottman R.F.D. #4</u>		Address <u>Quantico Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Heart Disease.</u> <u>H20-0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>15 Dec 1960</u> to <u>4 Jan 1961</u> that I last saw the deceased alive on <u>4 Jan 1961</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders M.D.</u>				DATE SIGNED <u>1/5/61</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Quantico</u>		22d. LOCATION (City, town, or county) (State) <u>Quantico Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart Salisbury Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>	



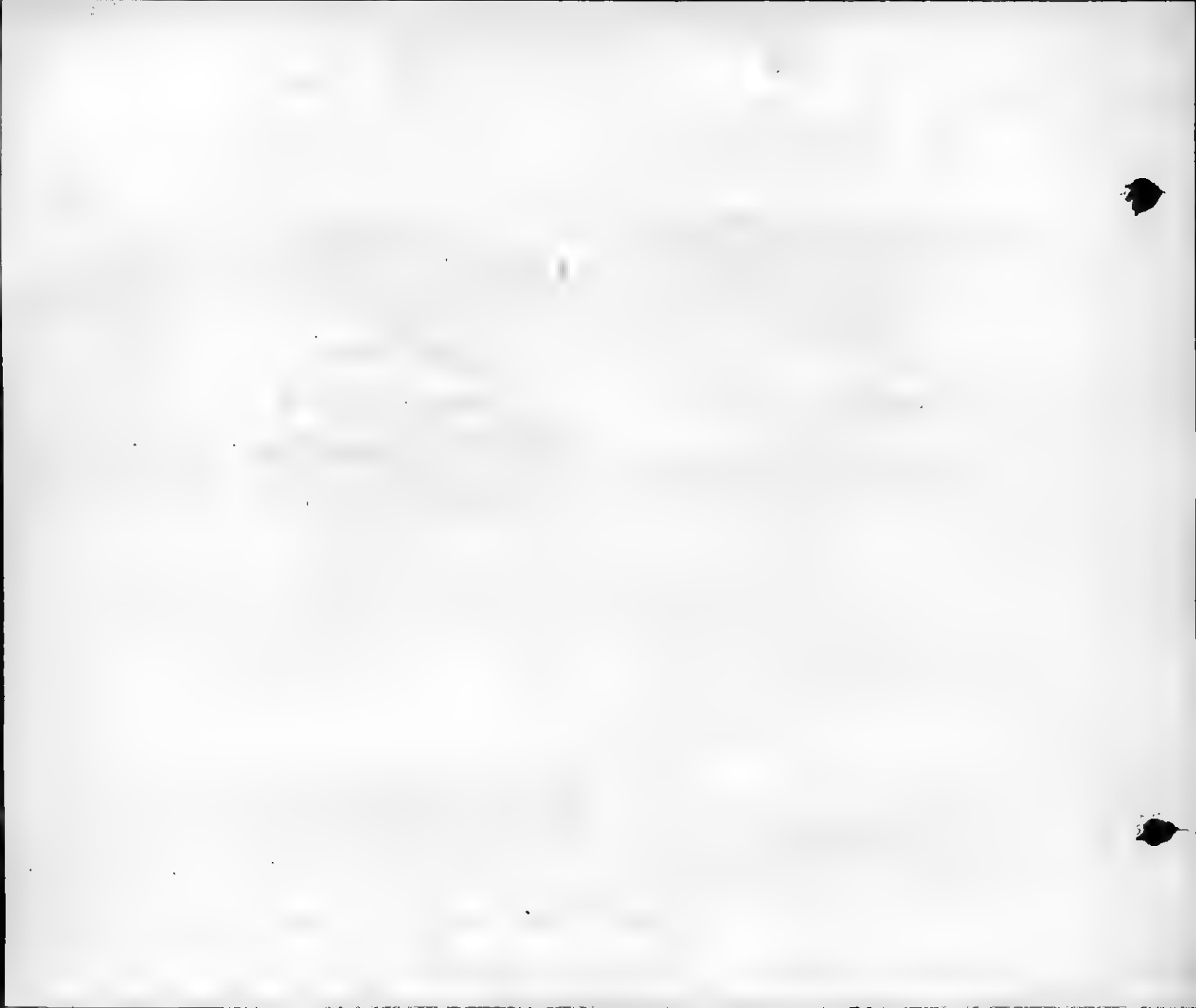
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1280

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01265

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>Laurel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Culver</u> Last <u>Culver</u>				4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 9, 1961</u>	
9. AGE (In years last birthday) <u>—</u> yrs		10. UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Culver</u>				14. MOTHER'S MAIDEN NAME <u>Doris Hitch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert Culver, Laurel, Del.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 650 gms)</u> 776X DUE TO (b) <u>approx 2 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/9</u> <u>1961</u> to <u>1/9</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> <u>1961</u> and that death occurred at <u>6:25</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Clifford C. Koles</u>				22b. DATE SIGNED <u>1/10/61</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>Medical Center Salisbury Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Laurel Del</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey Williamson Federalburg Md.</u> ADDRESS				25a. REC'D BY REGISTRAR <u>JAN 13 '61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles L. Evans</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

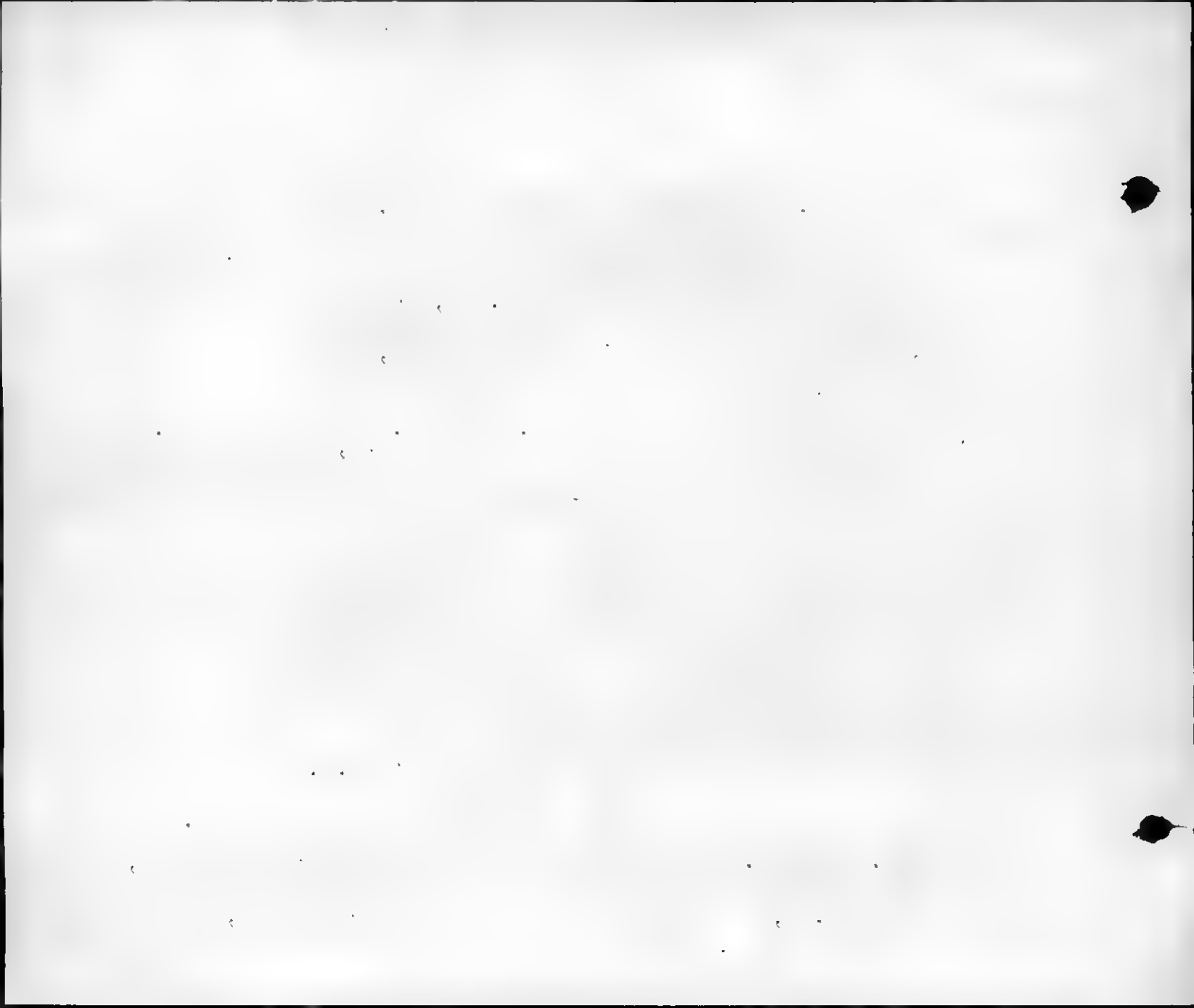
VR A15 (4)
15M 9/59

1281

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1266

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 116 E. Locust St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle DAVIS Last DAVIS		4. DATE OF DEATH Month JANUARY Day 26 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1906
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver (Operator)	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver (Operator)		10b. KIND OF BUSINESS OR INDUSTRY Taxi	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Joseph Davis		14. MOTHER'S MAIDEN NAME Clara Webster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Mrs. Gladys P. Davis (Wife)		Address 116 E. Locust St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 hours			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	20f. (City or town) N/A (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/26 1961 to 1/26 1961 , that (I) (we) last saw the deceased alive on 1/26 1961 , and that death occurred at 11:00 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Wilber R. Ellis Jr.		22b. DATE SIGNED Jan. 30/1961	
22c. PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis Jr.		22d. ADDRESS Medical Center Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 29, 1961	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City, town, or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE HOLIOWAY & COMPANY SALISBURY MARYLAND		25a. REC'D BY REGISTRAR JAN 31 '61	
		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1282

1207

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>X</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>1 R.D.# 3 Mt. Hermon Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRED THOMAS DAVIS</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 17 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 4, 1892</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employee-City Bus Co. (Driver)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wicomico Co. Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U S A</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>James Thomas Davis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kelley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Virgie E. Davis (Wife)</u> Address <u>H.D.# 3 Mt Hermon Road Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary artery occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary artery sclerosis</u> DUE TO <u>sen. yw.</u> (c) <u>gen. arteriosclerosis</u> " " PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <u>N/A</u>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>N/A 19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>	
20f. (City or town) <u>N/A</u> (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 23, 1954</u> to <u>Jan 17, 1961</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>Jan 17</u> 19 <u>61</u> , and that death occurred at <u>12</u> AM, from the causes and on the date stated above							
22a. SIGNATURE <u>Dr. Harry Mattax</u>				22b. DATE SIGNED <u>1/17/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Harry Mattax</u>	
22d. ADDRESS <u>Camden Ave. Salisbury, Maryland</u>							
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 20, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>				25a. REC'D BY REGISTRAR <u>JAN 19 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1283

(1268)

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARBLE</u>			
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>WILLIAM F ELLIOTT</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 26 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 20, 1899</u>	9. AGE (In years last birthday) <u>61</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SHOPS</u>			
11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>WILLIAM</u>				14. MOTHER'S MAIDEN NAME <u>WILLIAM</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-14-922</u>			
17. INFORMANT <u>Mrs. Lucy Elliott</u>				Address <u>MARBLE, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-24-61</u> to <u>1-26-61</u> , that (I) (we) last saw the deceased alive on <u>1-26-61</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Wilbur R. Elliott</u>				22b. DATE SIGNED <u>1-26-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>WILBUR R ELLIOTT JR</u>				22d. ADDRESS <u>MARBLE, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>JAN 29, 1961</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>MARBLE</u>				23d. LOCATION (City, town, or county) (State) <u>MARBLE, MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>SMITH FUNERAL HOME SHARPTOWN</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 1 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Conrad J. Fisk</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1284

1260

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown				c. LENGTH OF STAY IN 1b 12 Sharptown Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ferry Street				d. STREET ADDRESS 205 Record St.			
3. NAME OF DECEASED (Type or print) First EDGAR Middle SLEMONS Last ELLIS				4. DATE OF DEATH Month JAN. Day 1st Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 20, 1883	
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 4 Days 11 Hours Min. 		11. BIRTHPLACE (State or foreign country) Delmar, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroad Employee				10b. KIND OF BUSINESS OR INDUSTRY Delmar, Delaware			
13. FATHER'S NAME Monroe W. Ellis				14. MOTHER'S MAIDEN NAME Eliza Morris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO Unk		17. INFORMANT (Address) Mrs. J. Edwin Windsor (Daughter) Ferry St Sharptown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident - Hemiplegia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-vascular Disease DUE TO 20 yrs (c) Atherosclerosis, generalized							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval BETWEEN ONSET AND DEATH 2 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A 19 61 p. m. N/A				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A				20f. (City or town) (County) (State) N/A			
21. I certify that (I) (this hospital) attended the deceased from 14 Dec 1960 10:10 P.M. 1961 , that (I) (we) last saw the deceased alive on 31 Dec 1960 , and that death occurred at 10:10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. George G. Schlesinger				22b. DATE SIGNED Jan. 2 / 1961			
22c. PHYSICIAN'S NAME (Type) Dr. George G. Schlesinger				22d. ADDRESS Mardela, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 5, 1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) (State) Delmar, Delaware	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				25a. REC'D BY REGISTRAR JAN 5 '61			
25b. REGISTRAR'S SIGNATURE Arthur L. Hines				25c. REGISTRAR'S SIGNATURE Arthur L. Hines			



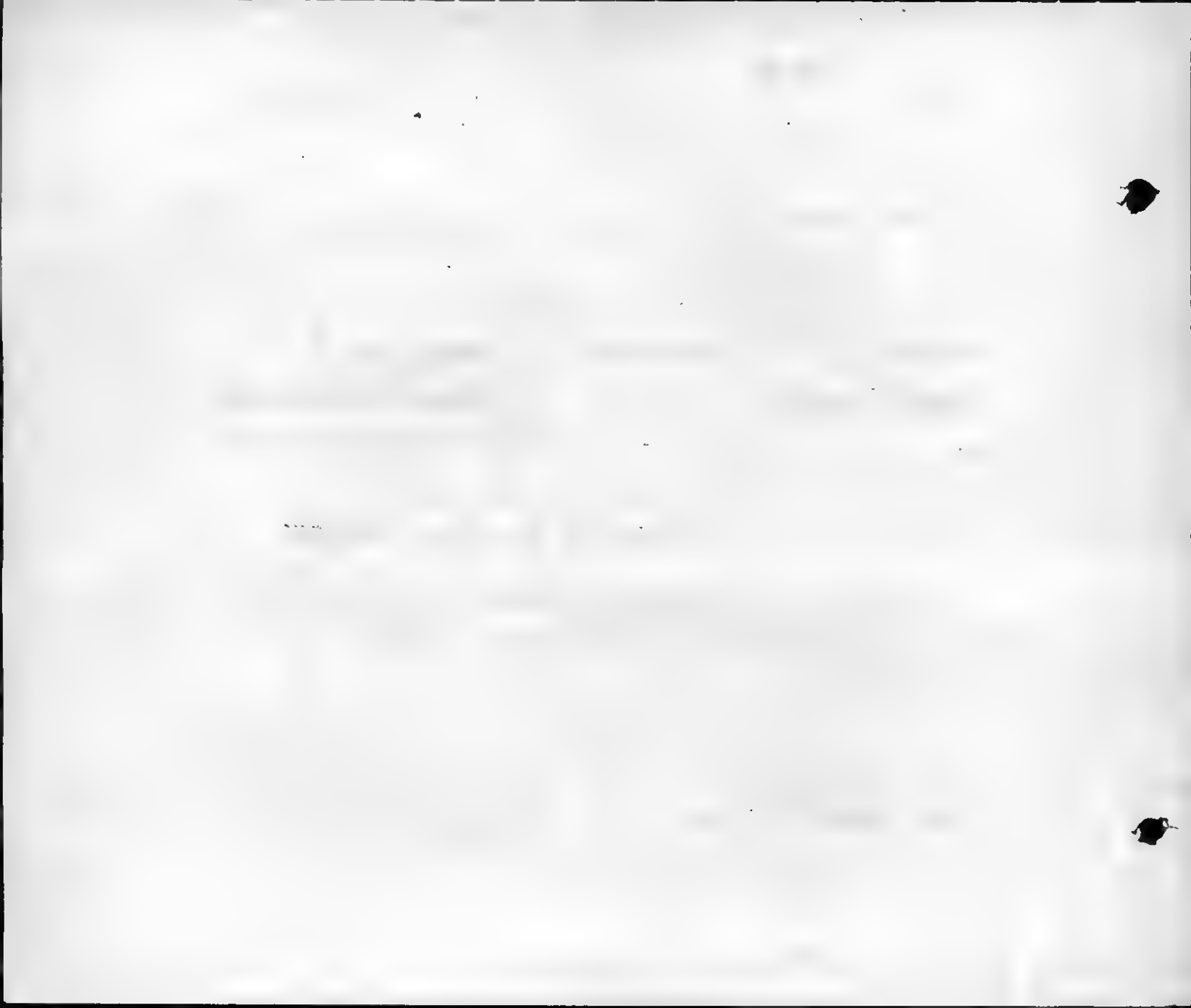
may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11270

1285

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>700 West St.</u>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>A.</u> Last <u>ERDMAN</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 15, 1877</u>	9. AGE (In years last birthday) <u>88</u> yrs	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John ERDMAN</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Bamberger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>221-07-0124</u>		17. INFORMANT Address <u>ELLA E. WINDOOR. Laurel, Del</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Postoperative prostatectomy</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/6</u> 19 <u>61</u> to <u>Jan 13</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 13</u> 19 <u>61</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Raymond M. Gou</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>1/14/61</u>			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/15/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ODD Fellows Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Laurel, Dela.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. HARVEY WILLIAMSON, FEDERALSBURG, MD</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>JAN 19 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any changes necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

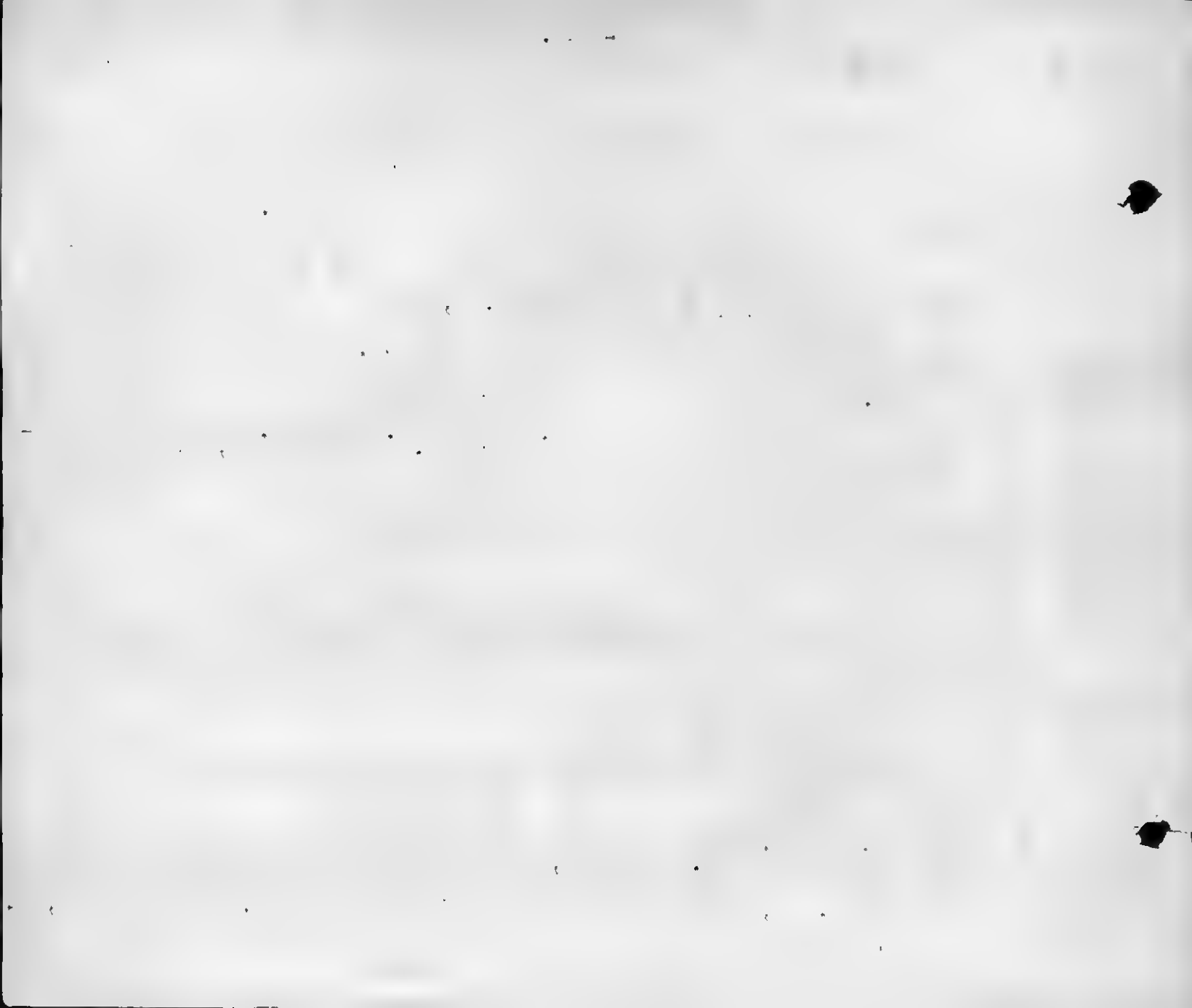
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1286

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1286

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN MD 12	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen Gen Hospital		d. STREET ADDRESS 206 Glen Ave.	
3. NAME OF DECEASED (Type or print) BEATRICE ELEANOR EVANS		4. DATE OF DEATH January 8th 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1876
9. AGE (in years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 84 Days 0 Hours 0 M. n. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William J. Brown		14. MOTHER'S MAIDEN NAME Cordela McAllen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. Mr. Lawrence L. Pusey Jr. (Nephew) 3233 Han- over Ave. Richmond 21, Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema			
420-1 DUE TO Cerebral Edema			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture 5th Dorsal Vertebra			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs at home			
20c. TIME OF INJURY Month, Day, Year 11 Hour 6 a.m. 1/8/61			
20d. INJURY OCCURRED: 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> Salisbury Wicomico Md			
20f. (City or town) (County) (State) Salisbury Wicomico Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Earl L. Royer M.D.			
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) January 11 /1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF Jan. 11, 1961			
22c. NAME OF CEMETERY OR CREMATORY Manokin Presbyterian Church Cem. Princess Anne, Md.			
22d. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY SALISBURY MARYLAND			
24b. REGISTRAR'S SIGNATURE Arthur L. Kiser			
24c. REC'D BY REGISTRAR JAN 13 '61			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 11/59

1287

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1272

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA General Hospital</i>				d. STREET ADDRESS <i>430 Priscilla St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>BERTHA</i> Middle <i>LEE</i> Last <i>FARLOW</i>				4. DATE OF DEATH Month <i>January</i> Day <i>3</i> Year <i>1961</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 2, 1890</i>		9. AGE in years last birthday) <i>70</i> yrs	IF UNDER 1 YEAR: Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Employee (Phillips Cleaners)</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>R.D.# Powellville, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>							
13. FATHER'S NAME <i>John Holland</i>				14. MOTHER'S MAIDEN NAME <i>Georgia A. Parker</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. William E. Farlow (Son) 430 Priscilla St Salisbury, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO (b) <i>P</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <i></i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>previous Coronary Thrombosis</i>						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>N/A</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>N/A</i> 19 <i>61</i> p. m. <i></i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>N/A</i>		20f. (City or town) <i>N/A</i> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 26</i> to <i>Jan 3</i> , 1961, that (I) (we) last saw the deceased alive on <i>Jan 3</i> , 1961, and that death occurred at <i>3:50</i> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Dr. Earl M. Beardsley</i>				22b. DATE SIGNED <i>Jan. 3, 1961</i>			
22c. PHYSICIAN'S NAME (Type) <i>Dr. Earl M. Beardsley</i>				22d. ADDRESS <i>Maryland Ave. Salisbury, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 6, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Charity Church Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>R.D.# Salisbury, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY & COMPANY</i>				25a. REC'D BY REGISTRAR <i>SALISBURY MARYLAND</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Hines</i>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

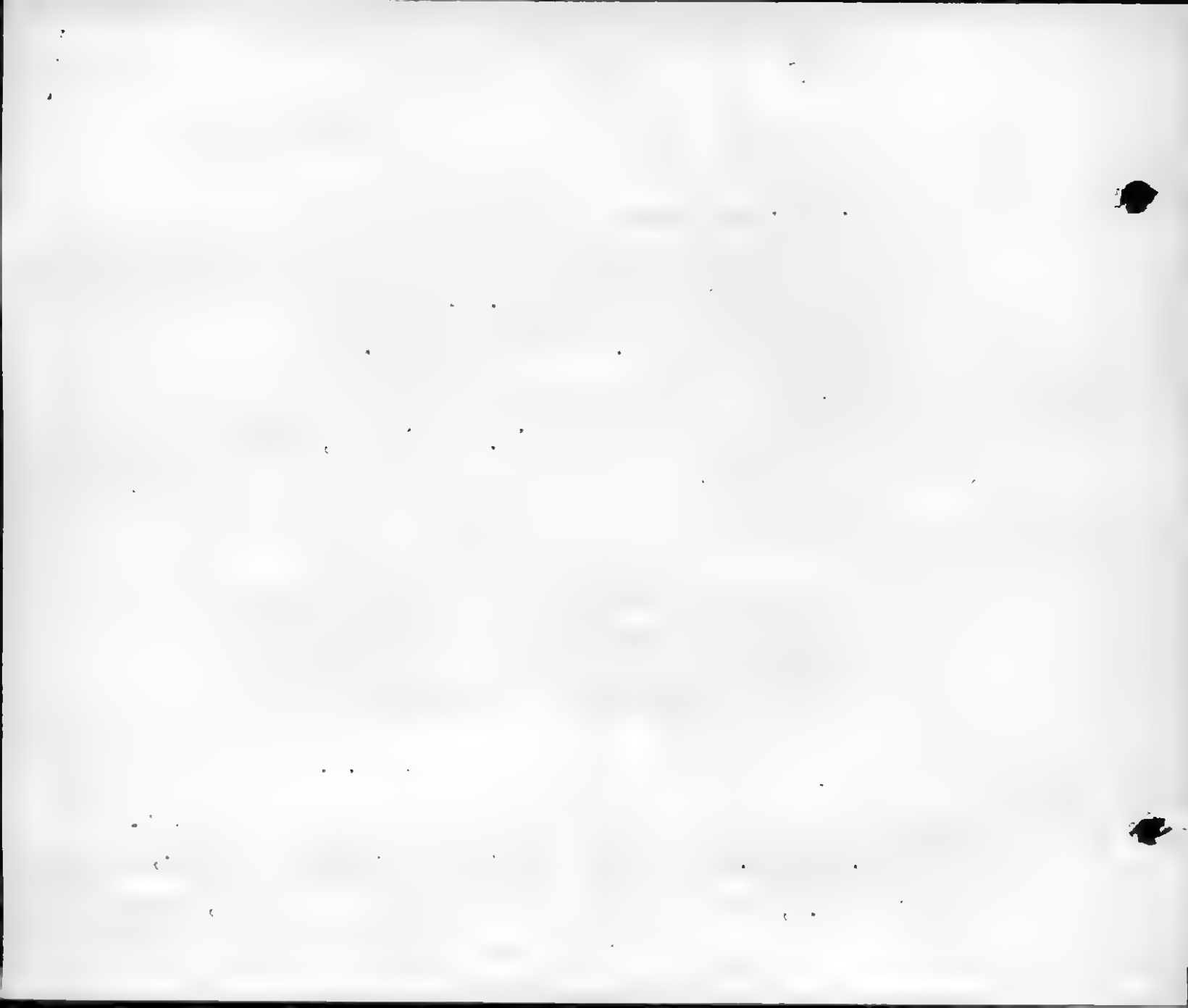
1288

CERTIFICATE OF DEATH

Item 3 Film 6280 2-6-61

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 111 Elizabeth St	
3. NAME OF DECEASED (Type or print) Werner ^{First} THOMAS ^{Middle} GARDNER ^{Last}		4. DATE OF DEATH Month JANUARY Day 30 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1880
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR: Months 81 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-SERVICE TRUCKING CO.		10b. KIND OF BUSINESS OR INDUSTRY Accomac Co. Virginia	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Gardner		14. MOTHER'S MAIDEN NAME Eva Johnson	
15. WAS DECEASED EVER IN U S ARMED FORCES? (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Mrs. Sarah P. Gardner (Wife)		Address 111 Elizabeth St, Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 540.0 DUE TO (b) Pyloric stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Cholera ulcer		INTERVAL BETWEEN ONSET AND DEATH 2-3 day yrs 1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 19 p. m. N/A		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> N/A	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 1:27 to 1:30 , 1961, that (I) (we) last saw the deceased alive on 1:30 , 1961, and that death occurred at 4:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Henry A. Briele		22b. DATE SIGNED Jan 31 / 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Henry A. Briele		22d. ADDRESS Medical Center Salisbury, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 2, 1961	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City, town, or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR SALISBURY MARYLAND	
25b. REGISTRAR'S SIGNATURE DATE FEB 2 '61		25c. REGISTRAR'S SIGNATURE Carl S. Kline	

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1289

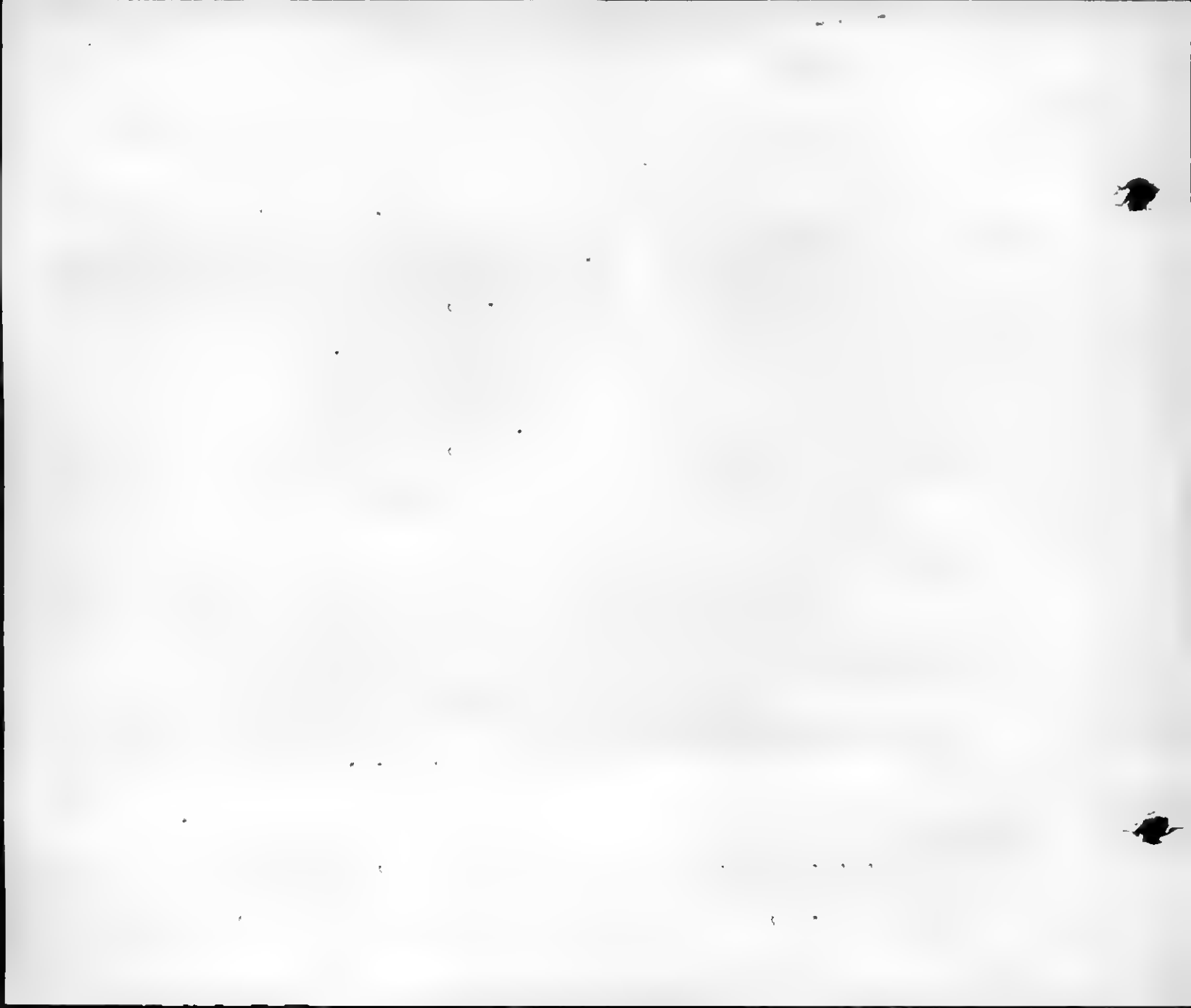
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1274

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela				c. LENGTH OF STAY IN 1b App: 5yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VIRGINIA Middle B. Last GORDY				4. DATE OF DEATH Month JANUARY Day 14th Year 19 61			
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 30, 1872	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR 11 Months 14 Days		IF UNDER 24 HRS. 14 Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work - Retired				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Lemuel Evans				14. MOTHER'S MAIDEN NAME Hester Hickman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. N/A			
17. INFORMANT Mrs. Edna Brittingham Address Berlin, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Virus - Pneumonia 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	
				20f. (City or town) N/A (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/4 7:10 A.M. to Jan 14, 1961 , that (I) (we) last saw the deceased alive on 1/13 1961 , and that death occurred at 11:14 M, from the causes and on the date stated above.							
22a. SIGNATURE H.S. Kuhlman				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Jan. 16 / 1961	
22c. PHYSICIAN'S NAME (Type) Dr. H.S. Kuhlman				22d. ADDRESS Sharptown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 16, 1961		23c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY		23d. LOCATION (City, town, or county) (State) SALISBURY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND				25a. REC'D BY REGISTRAR DATE JAN 18 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Evans	

(M)

(I)



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

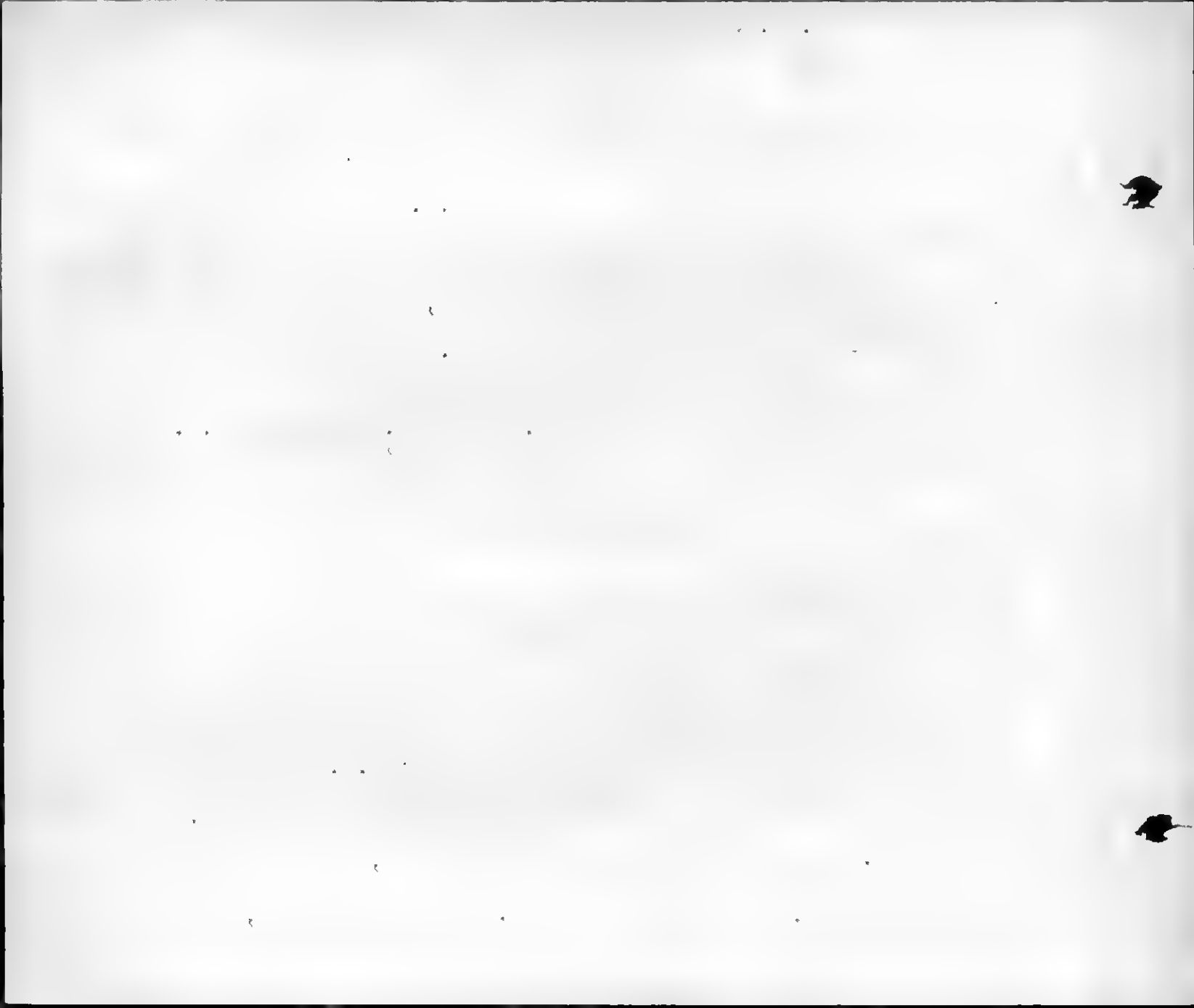
CERTIFICATE OF DEATH

1290

1275

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Delmar (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				e. STREET ADDRESS R.D.# 3			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HENRY Middle JACKSON Last GULLY				4. DATE OF DEATH Month JANUARY Day 25th Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1895	9. AGE (In years last birthday) 65 yrs	F UNDER 1 YEAR Months 6 Days 27	IF UNDER 24 HRS Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter-House Construction			10b. KIND OF BUSINESS OR INDUSTRY Miss.		11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Unk				14. MOTHER'S MAIDEN NAME MMK Sarah - - - - -			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Mrs. Dorothy B. Gully (Wife) R.D.#3 Delmar, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic Carcinoma in Mediastinum 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Carcinoma DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs 6 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A					
20c. TIME OF INJURY Month. N/A Day. 19 Year 19 Hour a. m. N/A p. m. N/A	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from August 19 1961 to Jan 25 1961 , that (I) (we) last saw the deceased alive on 25 Jan 1961 , and that death occurred at 1:10 A.M. from the causes and on the date stated above							
22a. SIGNATURE Joseph C. Fitzgerald				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> Jan. 27 1961		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph Fitzgerald				22d. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 27/1961		23b. DATE THEREOF Jan. 27/1961		23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND				25a. REC'D BY REGISTRAR JAN 31 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

ap



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

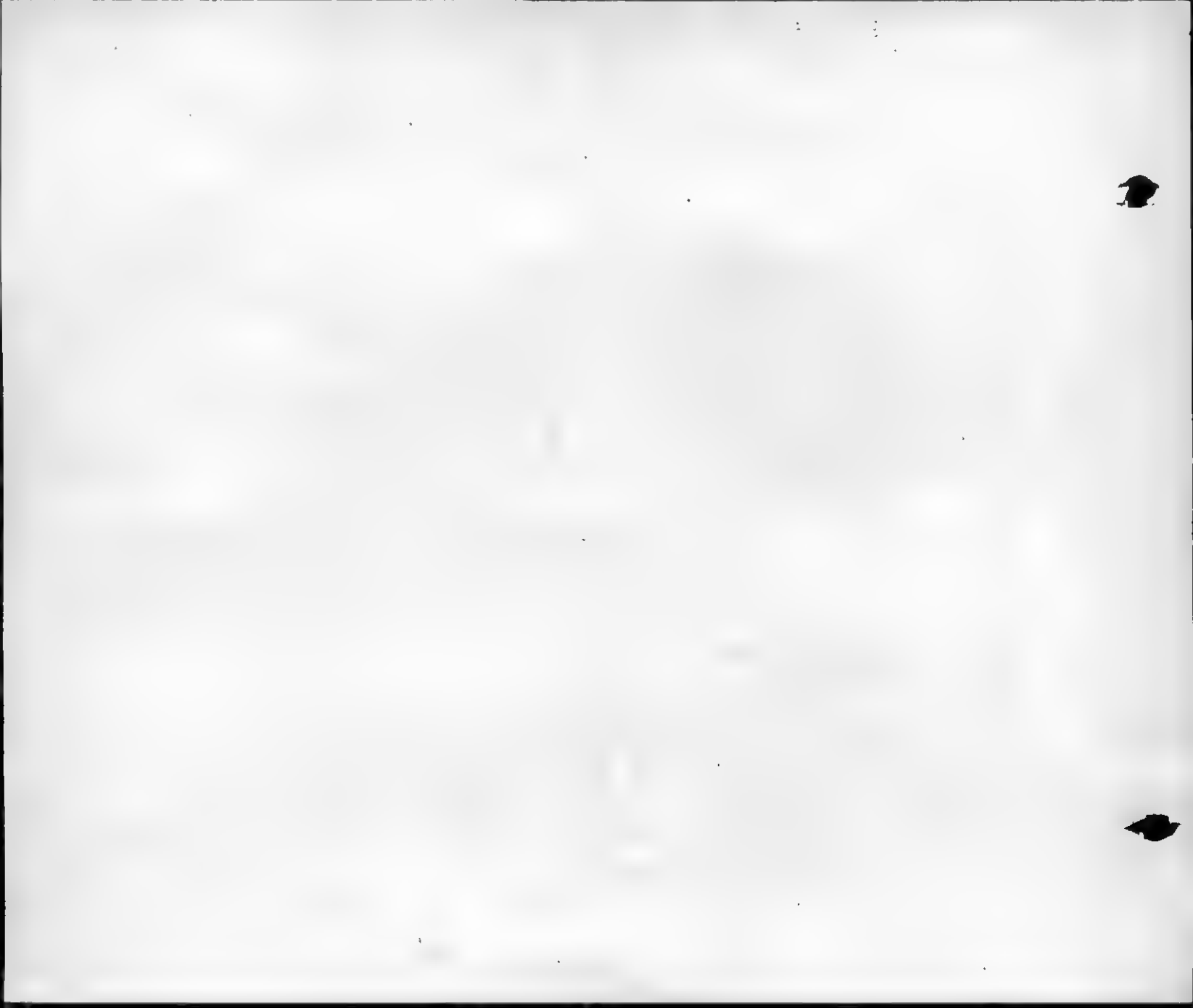
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1291

11276

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				d. STREET ADDRESS <u>415 FIVE</u>			
3. NAME OF DECEASED (Type or print) <u>LESTER A. HALL</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-1892</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>LEONUEL HALL</u>				14. MOTHER'S MAIDEN NAME <u>LIZZIE BAILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HETTIE HALL-DELMAR</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cor. Pulmonalis, Chronic</u> 01 DUE TO (b) <u>Chronic Bronchitis & Bronchial Asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 11, 1961</u> to <u>January 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>January 11, 1961</u> , and that death occurred at <u>12 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Daniel J. Gilmore</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>1-14-61</u>		<u>MT. OLIVE</u>		<u>DELMAR - DE.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. M. Marshall Co - Delmar, Del.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 16 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. S. Harris</u>	

MEDICAL CERTIFICATION



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1292

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

(127)

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 40 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chestnut Stt.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ellison Middle Rue Last Hastings				4. DATE OF DEATH Month Jan. Day 28 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 5, 1883	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Wood		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Archillius Hastings				14. MOTHER'S MAIDEN NAME Martha Rue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ida Hastings, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) Coronary arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Arteriosclerosis generalized				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 27 1961 to Jan 28 1961 , that (I) (we) last saw the deceased alive on Jan 27 1961 , and that death occurred at 2:30 A.M. from the causes and on the date stated above							
22a. SIGNATURE L. V. Sohler				22b. DATE SIGNED 1-30-61			
22c. PHYSICIAN'S NAME (Type) Dr. L.V. Sohler				22d. ADDRESS Delmar, Md.			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-30-61		23c. NAME OF CEMETERY OR CREMATORY Parsons		23d. LOCATION (City, town, or county) (State) Salisbury, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. S. Grand Co - Delmar, Del.				25a. REC'D BY REGISTRAR DATE JAN 31 '61		25b. REGISTRAR'S SIGNATURE Clifford L. Frame	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1293

CERTIFICATE OF DEATH

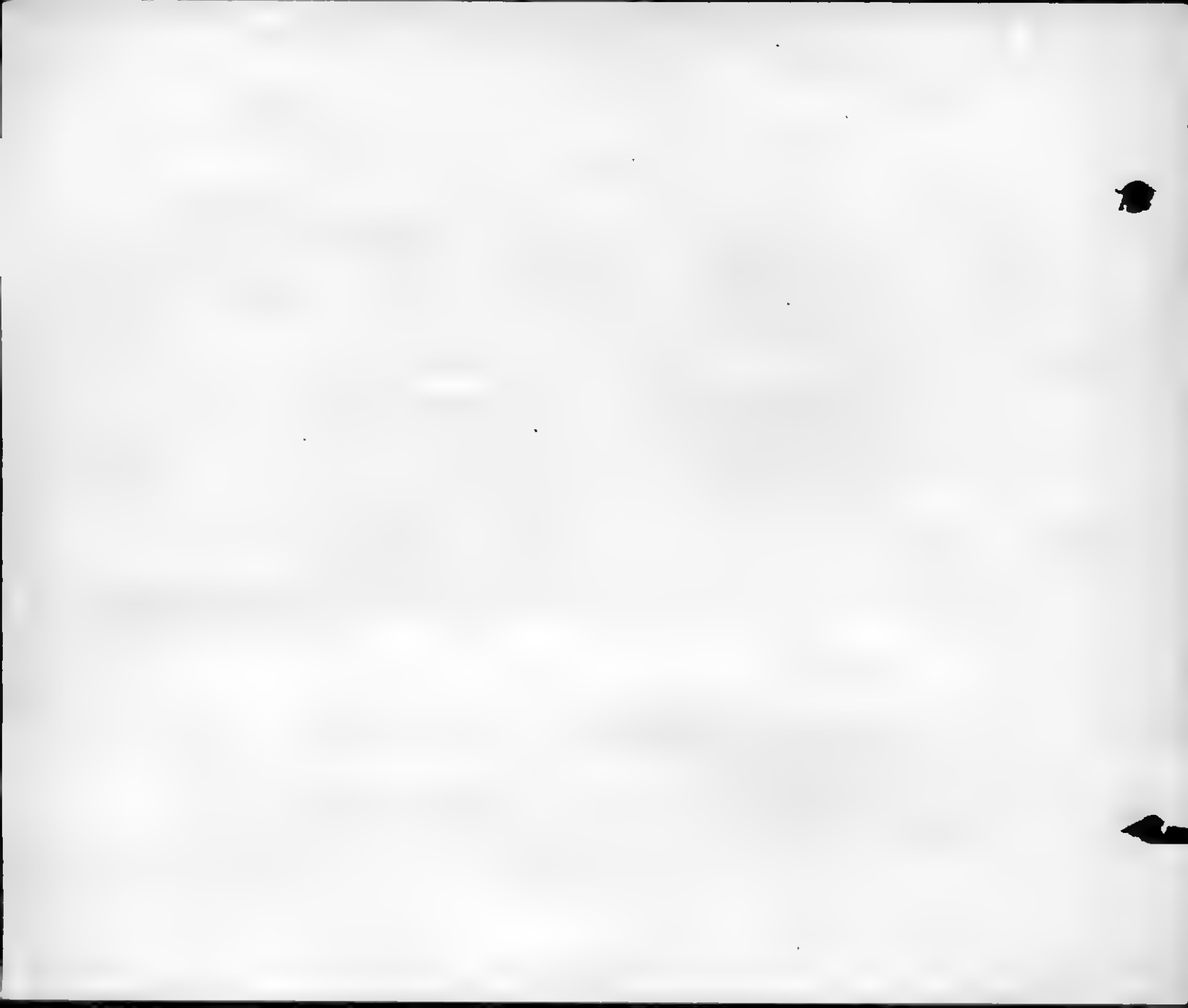
Item 8 311m279 1-27-61 et

12778

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>DELMAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>GROVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE</u> <u>HASTINGS</u>		4. DATE OF DEATH Month Day Year <u>JANUARY</u> <u>22</u> <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1891</u> <u>9-30-1899</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HOWARD SLACUM</u>		14. MOTHER'S MAIDEN NAME <u>MAGGIE HURLEY</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>221-09-4587</u>	
17. INFORMANT <u>Francis Waller - Delmar</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anelocarcinoma Uterus</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>9 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> <u>1960</u> to <u>Jan. 22</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 22</u> <u>1961</u> , and that death occurred at <u>11:27</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>John M. Bloxom III</u> M D		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM III</u>		22d. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-24-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge, Ind.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Mangel</u>		25a. REC'D BY REGISTRAR <u>JAN 24 '61</u>	
ADDRESS <u>Co. Delmar, Del</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>	

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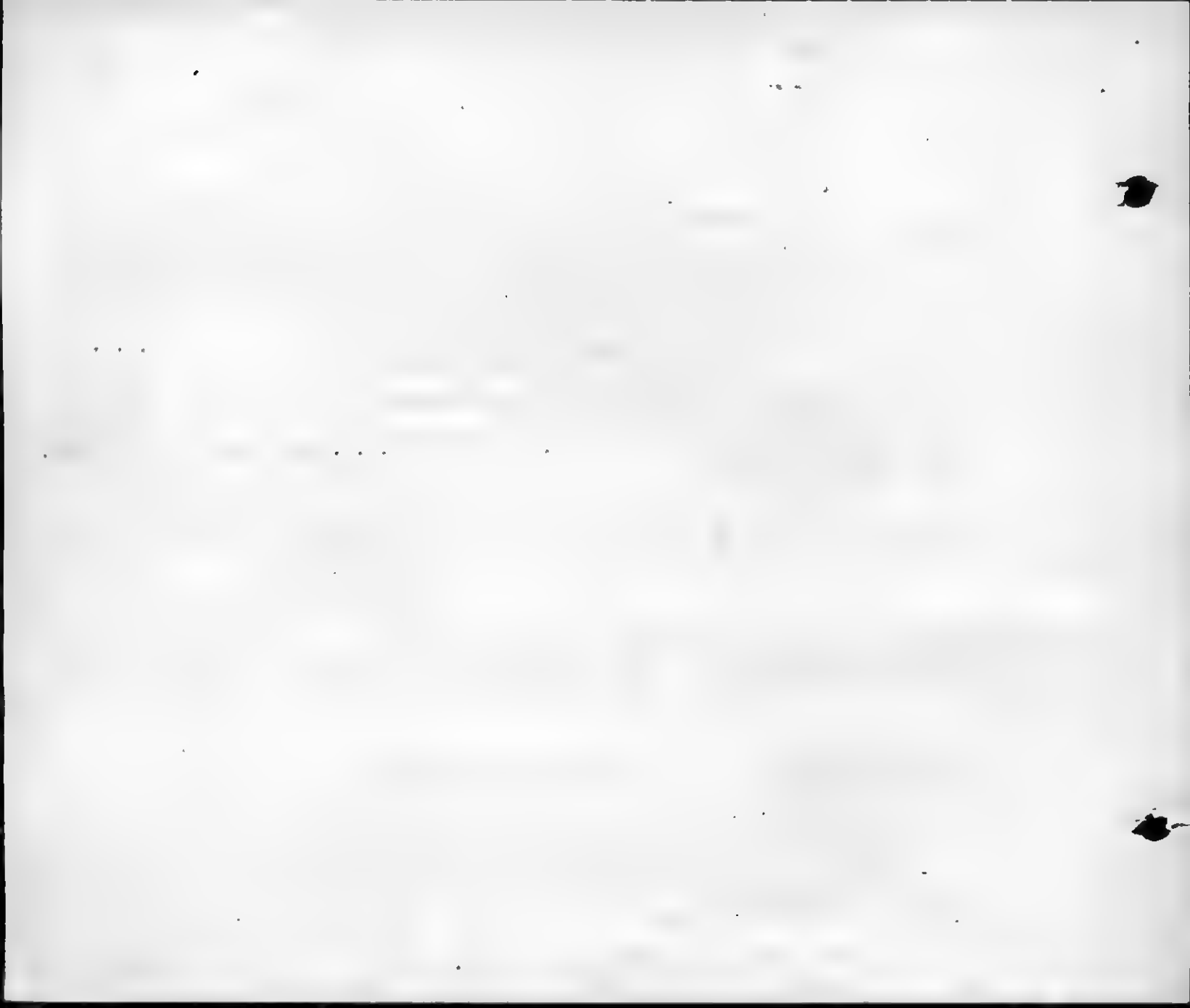
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1294

1127

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 8 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DEER'S HEAD STATE HOSP.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE			
f. STREET ADDRESS 6 MEADOW AVE.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ETTA Middle MARY Last HENRY				4. DATE OF DEATH Month JAN. Day 6 Year 1961			
5. SEX F		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/20/1864	
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME EDWARD HENRY				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NO			
17. INFORMANT MR. JOHN CLARK R.F.D.#1, CAMBRIDGE, MARYLAND				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) ARTERIOSCLEROTIC CARDIOVASCULAR DIS. (c) ARTERIOSCLEROSIS GENERAL PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3d. (b) Years (c) ?							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour 0 m 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4.11 1960 to 1.6 1961, that (I) (we) lost saw the deceased alive on 1.6 1961, and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE V. Juerman				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL							
23b. DATE THEREOF 12/8/1961							
23c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEMORIAL PARK							
23d. LOCATION (City, town, or county) (State) CAMBRIDGE, MARYLAND							
24. FUNERAL DIRECTOR'S SIGNATURE LE COMPTE FUNERAL SERVICE, CAMBRIDGE, MARYLAND							
25a. REC'D BY REGISTRAR JAN 10 '61							
25b. REGISTRAR'S SIGNATURE Arthur L. Kline							



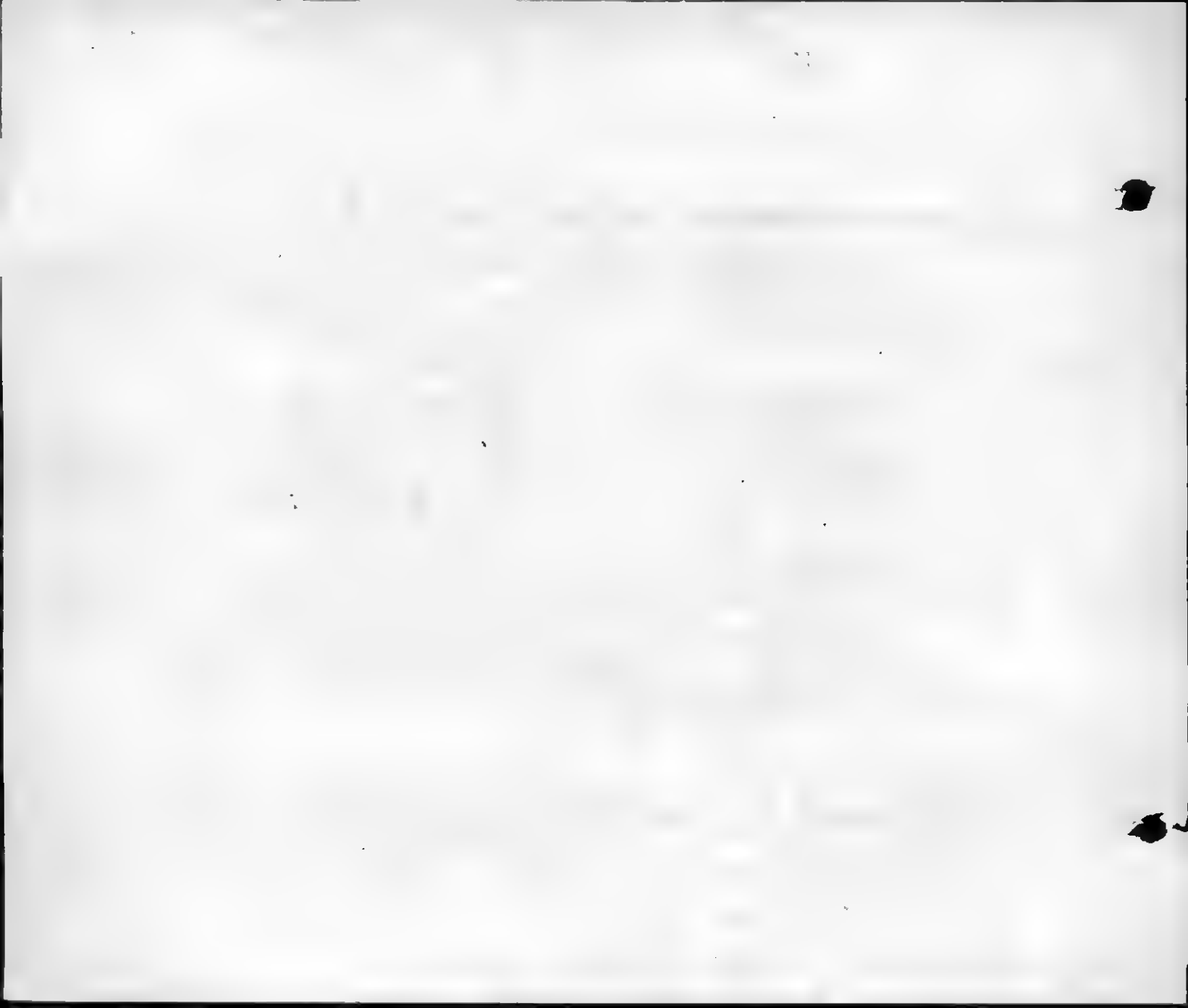
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1295

1280

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>Chincoteague</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>Pine Ridge Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hillman Daniel Hopkins Jr.</u>				4. DATE OF DEATH Month Day Year <u>January 12, 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 13, 1923</u>	9. AGE (In years last birthday) <u>37</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUS Driver</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Trailway Bus</u>			11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Hillman D. Hopkins Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Janie Jones</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Barbara A. Hopkins - Chincoteague, Va.</u>			Address
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion with Myocardial Infarction</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 27, 1960</u> to <u>Jan 12, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 12, 1961</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							22b. DATE SIGNED <u>1/12/61</u>
22a. SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. ADDRESS <u>Pine Bluff Road, Salisbury, Md.</u>			
22c. PHYSICIAN'S NAME (Type)							
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 15, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Red men Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Chincoteague, Va.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salyer</u>		ADDRESS <u>Chincoteague, Va.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 19 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1296

(1281

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bivalue</u>	
c. LENGTH OF STAY IN 1b <u>26 Days</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Gen. Hospital</u>	
3. NAME OF DECEASED (Type or print) <u>Laura Ellen Horsman</u>		4. DATE OF DEATH <u>Jan. 17 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-1883</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Beechman Haxington</u>		14. MOTHER'S MAIDEN NAME <u>Delia Dunn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Lloyd Horsman</u>		Address <u>Bivalue Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.00</u> <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus. Fractured Hip.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Fell in Home - Fractured hip.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>8</u> o. m. <u>12 Dec.</u> 19 <u>60</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12 Dec. 1960</u> to <u>17 Dec. 1961</u> , that (I) (we) last saw the deceased alive on <u>17 Dec. 1961</u> and that death occurred at <u>5</u> PM, from the causes and on the date stated above			
22a. SIGNATURE <u>Richard H. Saunders</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Saunders M.D.</u>		22d. ADDRESS <u>Nanticoke Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/19/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bivalue Cem.</u>		23d. LOCATION (City, town, or county) <u>Bivalue, Md.</u> (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messert</u>		24a. ADDRESS <u>Bivalue, Md.</u>	
25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>JAN 23 '61</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

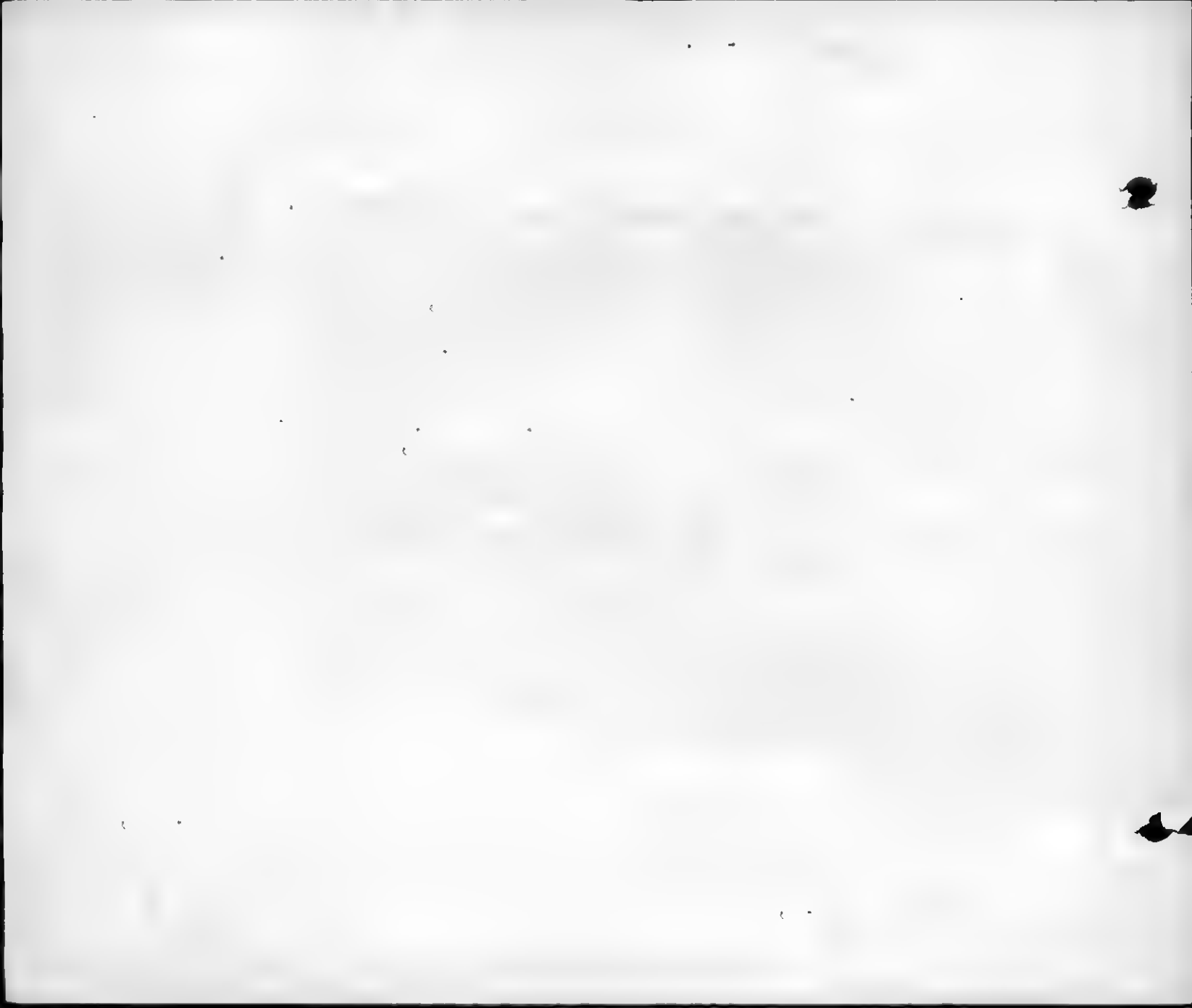
VR A15 (4)
15M 9/59

1297

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1296

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sevenside General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>CARLTON</i> Middle <i>PERCY</i> Last <i>Howard</i>		4. DATE OF DEATH Month <i>JAN.</i> Day <i>30</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 16, 1893</i>
9. AGE (In years last birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR Months <i>67</i> Days <i>67</i> Hours <i>67</i> Min <i>67</i>	11. IF UNDER 24 HRS Months <i>67</i> Days <i>67</i> Hours <i>67</i> Min <i>67</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Painting</i>	
11. BIRTHPLACE (State or foreign country) <i>Wico. County Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Granville R. Howard</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Jackson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unk</i>		16. SOCIAL SECURITY NO. <i>Unk</i>	
17. INFORMANT <i>Mrs. Hazel F. Howard (Wife)</i>		Address <i>Chestnut St Hebron, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> 586X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cholecystectomy (This morning)</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>N/A</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>N/A</i> 19 <i>19</i> p. m. <i>N/A</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>N/A</i>		20f. (City or town) (County) (State) <i>N/A</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>1-23-1961</i> to <i>1-30-1961</i> , that (I) (we) last saw the deceased alive on <i>1-30-1961</i> , and that death occurred at <i>5:00 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>William H. Fisher</i>		22b. DATE SIGNED <i>Jan. 30, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>William H. Fisher</i>		22d. ADDRESS <i>Medical Center</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Feb. 3, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Hebron Cemetery</i>		23d. LOCAT ON (City, town, or county) (State) <i>Hebron, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY & COMPANY</i>		ADDRESS <i>SALISBURY MARYLAND</i>	
25a. REC'D BY REGISTRAR <i>DATE FEB 2 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur J. Hume</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deaths necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

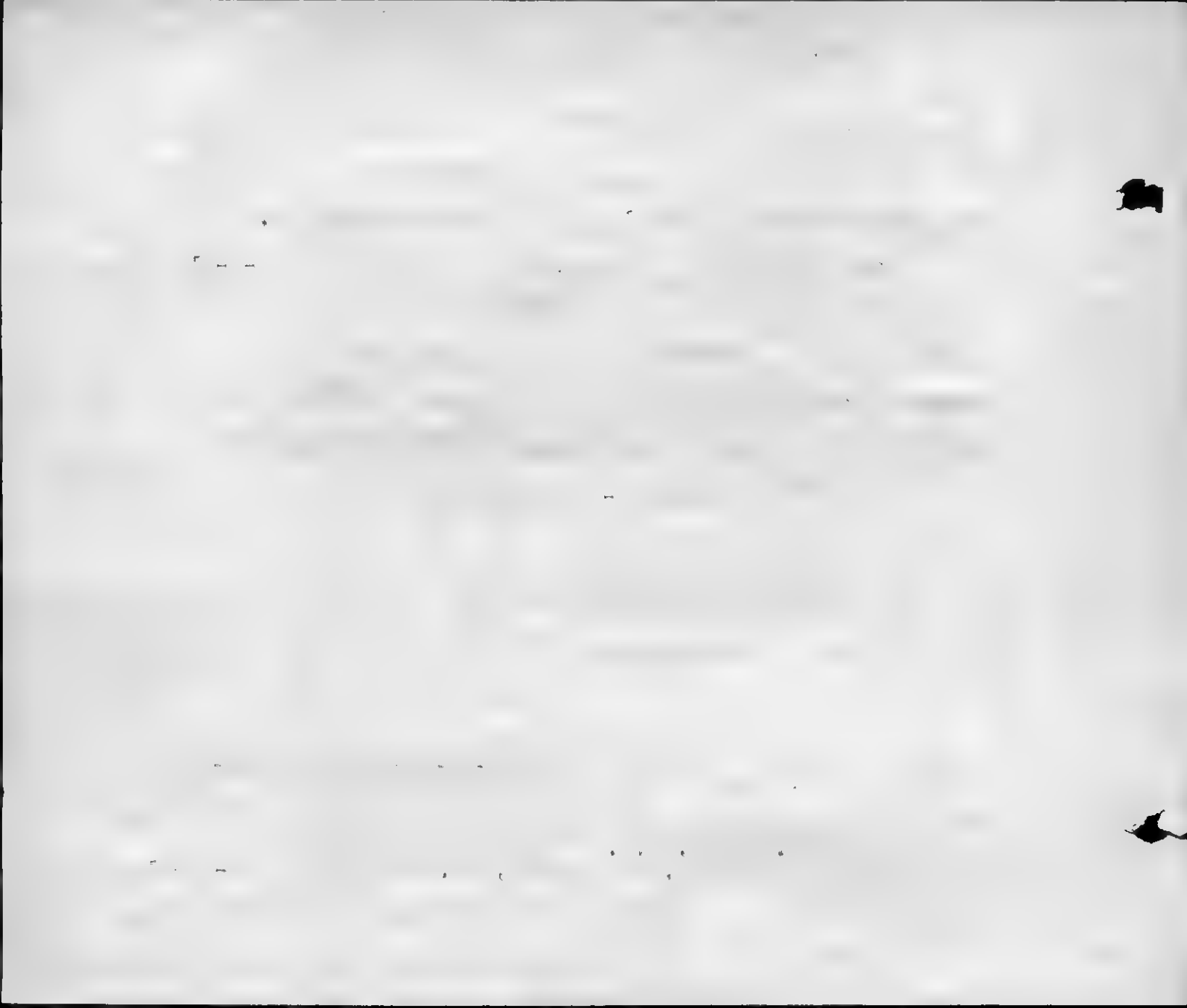
1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1298 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1283

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 420 Delaware St.	
3. NAME OF DECEASED (Type or print) John Wesley Hudson		4. DATE OF DEATH 1-6-61	
5. SEX M		6. COLOR OR RACE C	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct-9-1918	
9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) 42 yrs.		10. BIRTHPLACE (State or foreign country) U.S.A.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hudson Sr		14. MOTHER'S MAIDEN NAME Vergie Dasset	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? WWII		16. SOCIAL SECURITY NO. 214-1066300	
17. INFORMANT Dorothy Hudson		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 49 IX DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		DATE SIGNED 1-16-61	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE TAKEN FOR 1-10-61	
22c. NAME OF CEMETERY OR CREMATORY Knox Acres Cem		22d. LOCATION (City, town, or country) Salisbury Md	
23. FUNERAL DIRECTOR Booker McWest		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Earl L. Royer	
DATE JAN 17 '61			



Item 8 Film 2-20-61 et

CERTIFICATE OF DEATH

Reg. Dist. No.

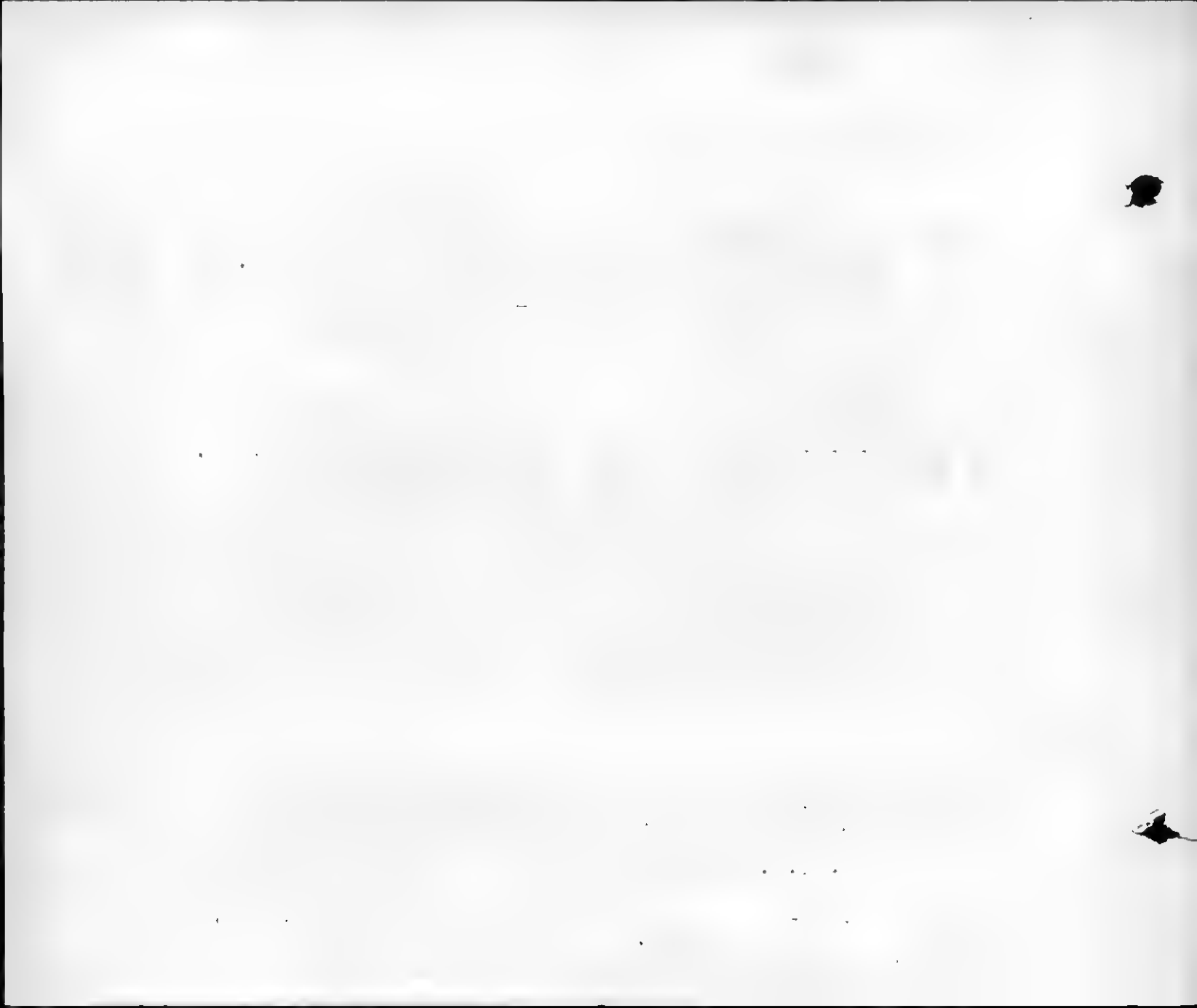
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1284

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 50 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 208 Elizabeth				d. STREET ADDRESS 208 Elizabeth			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LOVEY Middle LEE Last HURT				4. DATE OF DEATH Month Jan. Day 24 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-1861 / 1863		9. AGE (In years lost birthday) yrs. 97	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Smoot				14. MOTHER'S MAIDEN NAME Ann Hackett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Addie Snowden, Delmar, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis cerebral and generalized DUE TO (c) 15 yrs				INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 50 , to Jan 24 1961 , that I last saw the deceased alive on Jan 23 1961 , and that death occurred at 4:00 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delmar, Md. DATE SIGNED 12-26-61							
ACTUAL SIGNATURE R. V. Sohler		M.D. Delmar, Md.					
PHYSICIAN'S NAME (Type) Dr. L.V. Sohler		Delmar, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-61		22c. NAME OF CEMETERY OR CREMATORY Mount Olive		22d. LOCATION (City, town, or county) (State) Delmar, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Marvel Co - Delmar, Del				24a. REC'D BY REGISTRAR DATE JAN 30 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

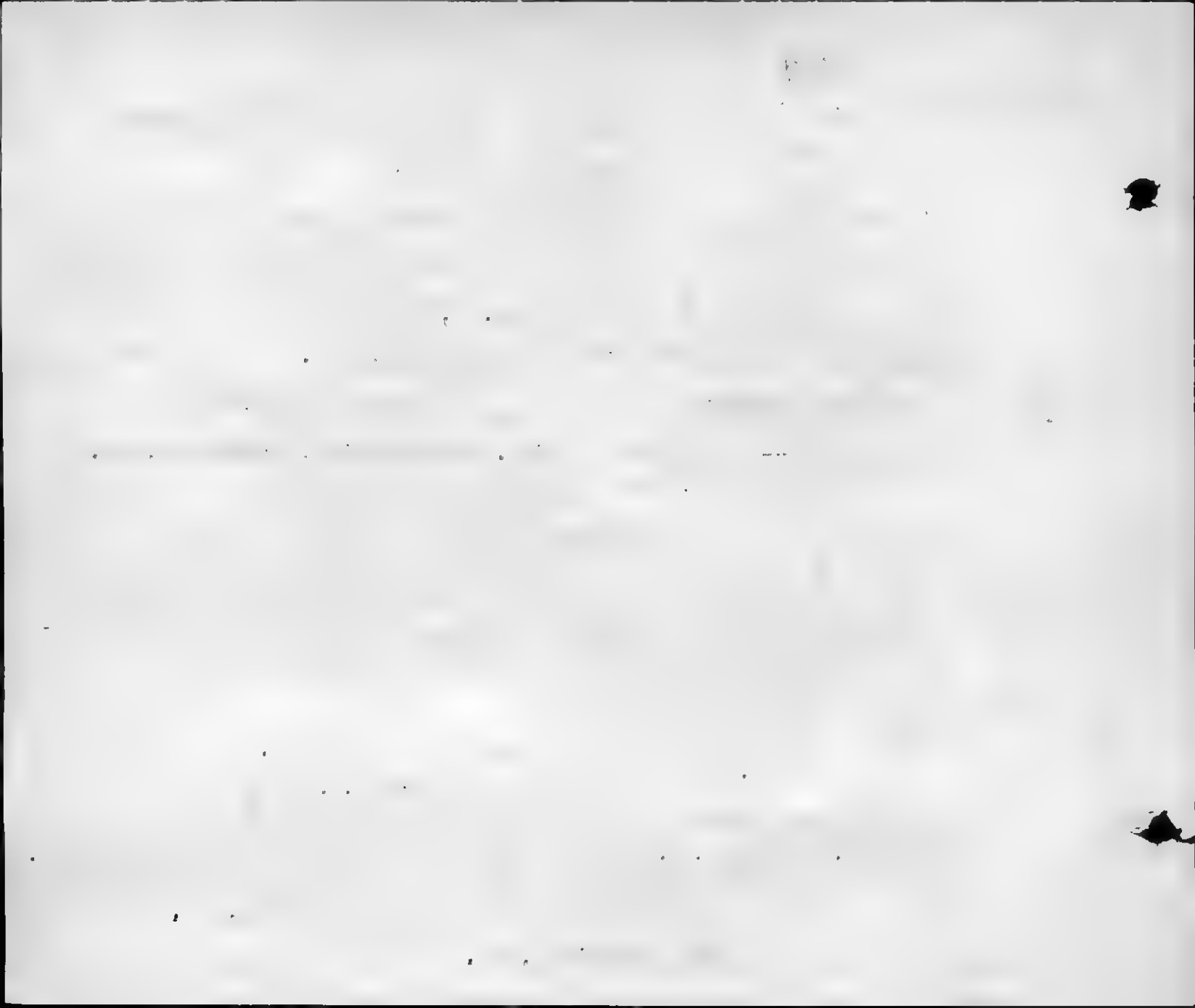
1300

61285

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 580 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital		2. USUAL RESIDENCE (Where deceased lived, if not put on: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 101 Fairmount Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bettie First Middle Last Lula 4. DATE OF DEATH January 31 19 61		5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 2, 1896 9. AGE (In years last birthday) 64 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 10b. KIND OF BUSINESS OR INDUSTRY Domestic 11. BIRTHPLACE (Country & State, or foreign country) Talladega, Ala. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Anthony Parson 14. MOTHER'S MAIDEN NAME Annie Parson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Rev. John English, Cambridge, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis, general (c) Diabetes mellitus with gangrene of right foot PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus with gangrene of right foot		INTERVAL BETWEEN ONSET AND DEATH Yrs ?	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Beer's Head State Hospital; Salisbury, Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1959 , to Jan. 31, 1961 , that (I) (we) last saw the deceased alive on Jan. 31, 19 61 , and that death occurred at 8:05 A.M. from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman 22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.		22b. DATE SIGNED 1/31/61 22d. ADDRESS Beer's Head State Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/5/1961	
23c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery		23d. LOCATION (City, town or county) (State) Cambridge, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Herbert M. Sells		25a. REC'D BY REGISTRAR DATE FEB 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

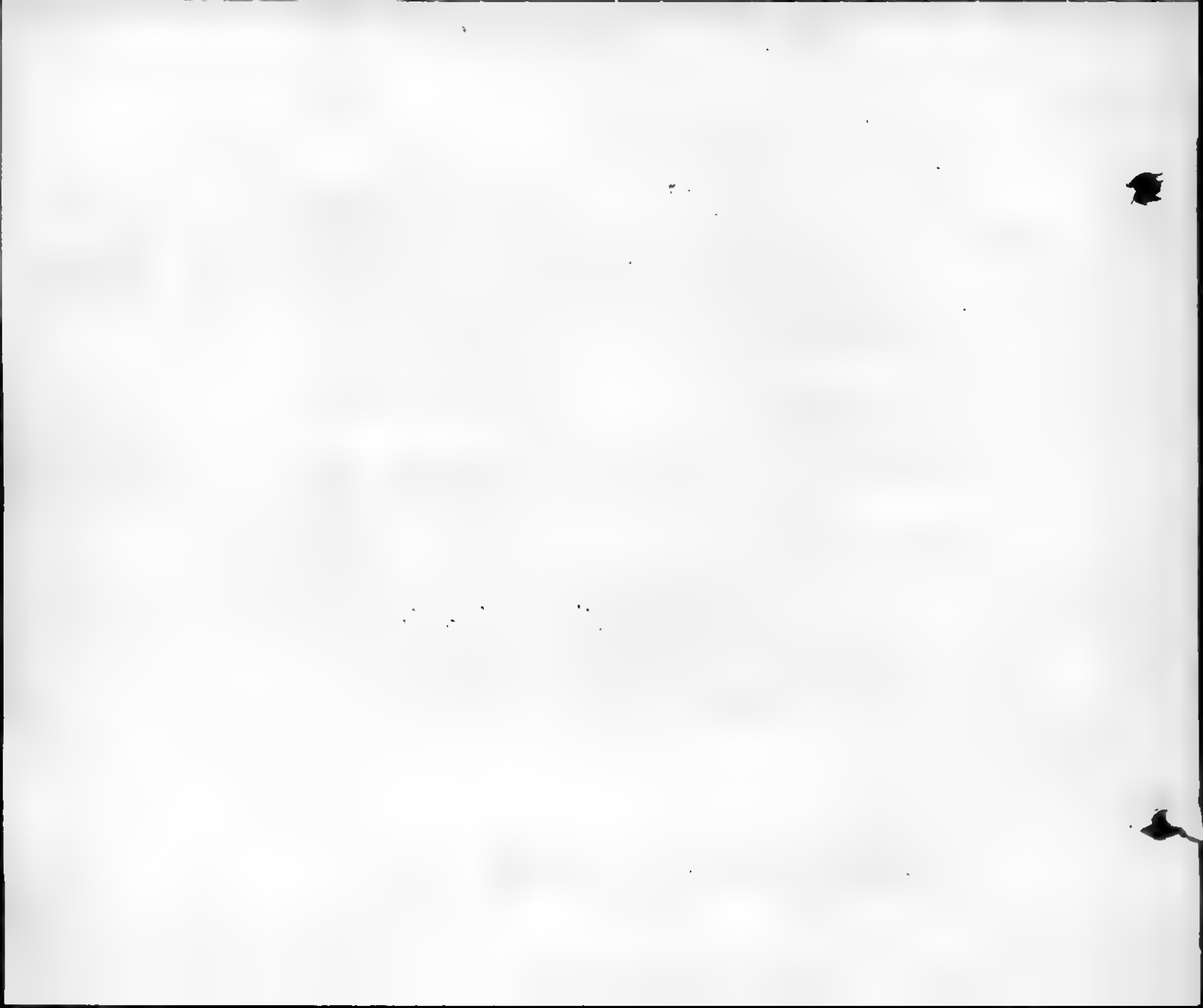
1 1301 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

1286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
c. LENGTH OF STAY IN 1b <u>8 mos</u>				d. STREET ADDRESS <u>657 Fitzwater St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>657 Fitzwater St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Colon</u> Middle <u>G.</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>AA</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-6-1960</u>	
9. AGE (In years last birthday) <u>0</u> yrs		IF UNDER 1 YEAR: Months <u>8</u> Days <u></u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS: Months <u></u> Days <u></u> Hours <u></u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Colon G. White</u>				14. MOTHER'S MAIDEN NAME <u>Janice Neal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO <u></u>			
INFORMANT <u>Miss Janice Neal</u> Address <u>Salisbury, Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute gastroenteritis</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 Jan 1961</u> to <u>7 Jan 1961</u> , that I last saw the deceased alive on <u>7 Jan 1961</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>652 W. main Salisbury, Md</u> DATE SIGNED <u>13 Jan 61</u> ACTUAL SIGNATURE <u>E. A. Purvell</u> M.D. PHYSICIAN'S NAME (Type) <u>E. A. Purvell, M.D. 652 W. main St - Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>1-10-61</u>		<u>GREEN ACRES Cem.</u>		<u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley</u> ADDRESS <u>Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford L. Kiser</u>	

MEDICAL CERTIFICATION



1
 TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1302
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

1283

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN lb <u>12</u> d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>1 Monticello & Federal Sts</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM FRANKLIN Johnson</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 9 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 23, 1908</u>	
9. AGE (In years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u>		11. IF UNDER 24 HRS Hours <u>16</u> Min <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner & Operator-Johnson Radio & Sales & Service</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>T.V. Nanticoke, Maryland</u>			
13. FATHER'S NAME <u>William C. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>N/A</u>			
17. INFORMANT <u>Mrs. Margaret A. Johnson (Wife)</u>				18. ADDRESS <u>Monticello & Federal Sts. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1120-1</u> (c) <u>16 mos</u>						INTERVAL BETWEEN ONSET AND DEATH <u>16 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>N/A</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1959</u> to <u>June 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 31 1960</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William D. Gray</u>				22b. PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>		22c. DATE SIGNED <u>January 9, 1961</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan. 13, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>			
25a. REC'D BY REGISTRAR <u>JAN 13 '61</u>				25b. REGISTRAR'S SIGNATURE <u>C. J. S. Kline</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 11/59

1303

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1288

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princess Anne 171</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dana H</u> First Middle Last 4. DATE OF DEATH <u>JANUARY 18 1961</u> Month Day Year			5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>OCT 27 1951</u> 9. AGE (In years last birthday) <u>79</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>John Jones</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Peyton</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. John Widdowson</u> Address <u>Mt Vernon Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Branch pneumonia</u> DUE TO <u>9 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO <u>9 days</u> (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from <u>12/30 1960</u> to <u>1/15 1961</u> , that (I) (we) last saw the deceased alive on <u>1/15 1961</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Frederic R. Gramse</u> 22c. PHYSICIAN'S NAME (Type)				22b. DATE SIGNED 22d. ADDRESS M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>		<u>1/20/61</u>		<u>John Wesley</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Herman Prentiss Anne Md.</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>JAN 24 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Gramse</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1
FOR STATE
HEALTH DEPT.

1304

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

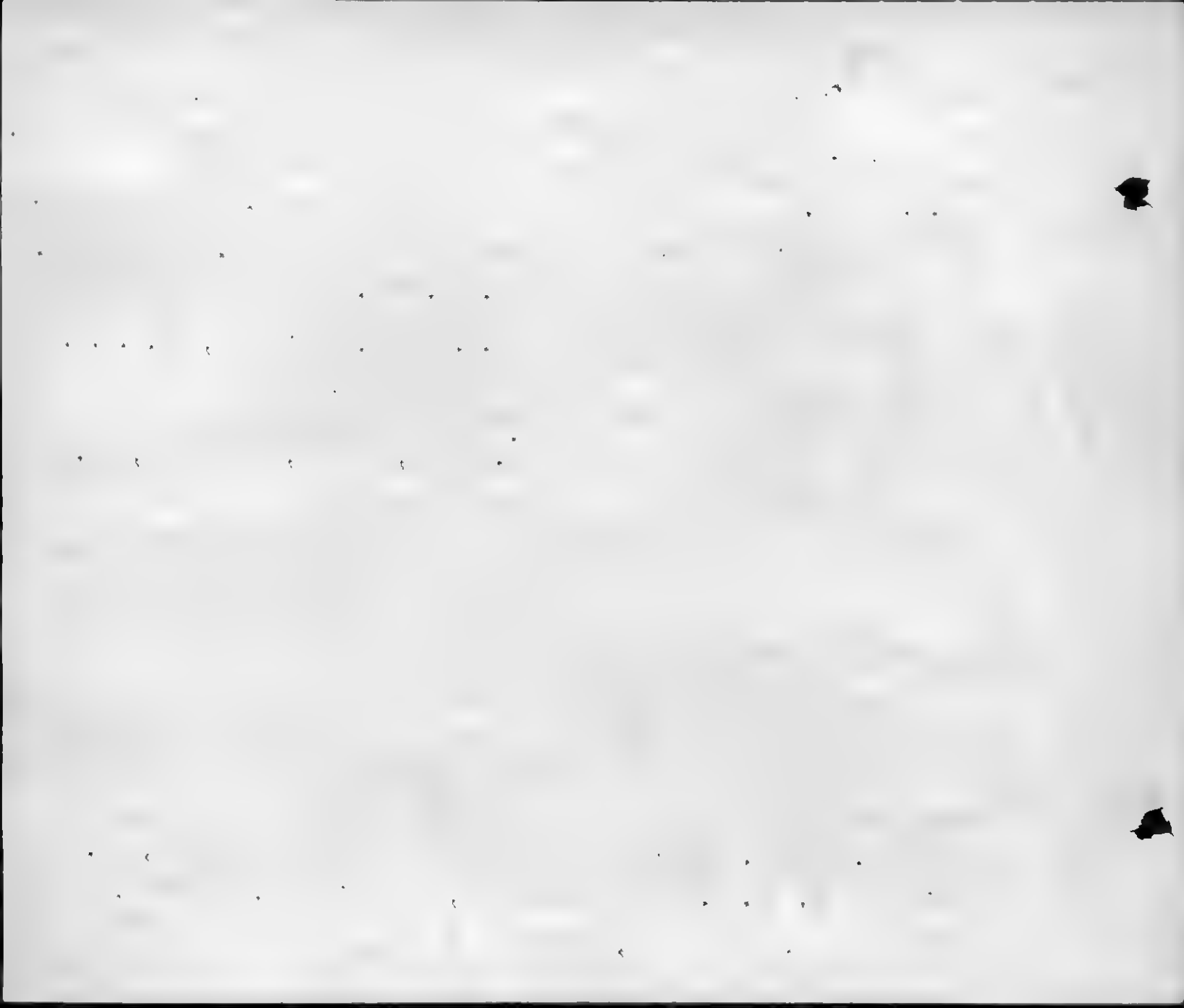
61289

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) P.G. Hospt.		d. STREET ADDRESS 220 Newton Street.	
3. NAME OF DECEASED (Type or print) Dennis Mark Jones	4. DATE OF DEATH Month Jan. Day 28 Year 61.	5. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21. 1961.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) P.G. Hospt. Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Vivian Mumford Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Vivian Mumford Jones (Mother)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Jan. 31. 61.	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery,		22d. LOCATION (City, town, or country) (State) Salisbury, Maryland.	
23. FUNERAL DIRECTOR Holloway & Co. Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE JAN 31 '61	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

VS. A15ME
SM 7/59

2082354XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1305

CERTIFICATE OF DEATH

Reg. Dist. No.

61290

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>400 Woodcrest Ave.</u>				d. STREET ADDRESS <u>400 Woodcrest Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank A. Keller</u>				4. DATE OF DEATH Month Day Year <u>January 2, 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 13, 1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Maintenance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>State Rds. Comm</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Benjamin Keller</u>				14. MOTHER'S MAIDEN NAME <u>Maria Plantz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				INFORMANT <u>400 Woodcrest Ave. Miss Radella Keller Salisbury, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma</u> 1. <u>19.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/4</u> , 19 <u>30</u> , to <u>1/2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>60</u> , and that death occurred at <u>9:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>H. R. [Signature]</u> M.D. <u>Salisbury, Md.</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/4/61</u>		<u>St. Andrews Episcopal</u>		<u>Princess Anne, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
				<u>Princess Anne, Md.</u>		<u>DATE 6 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

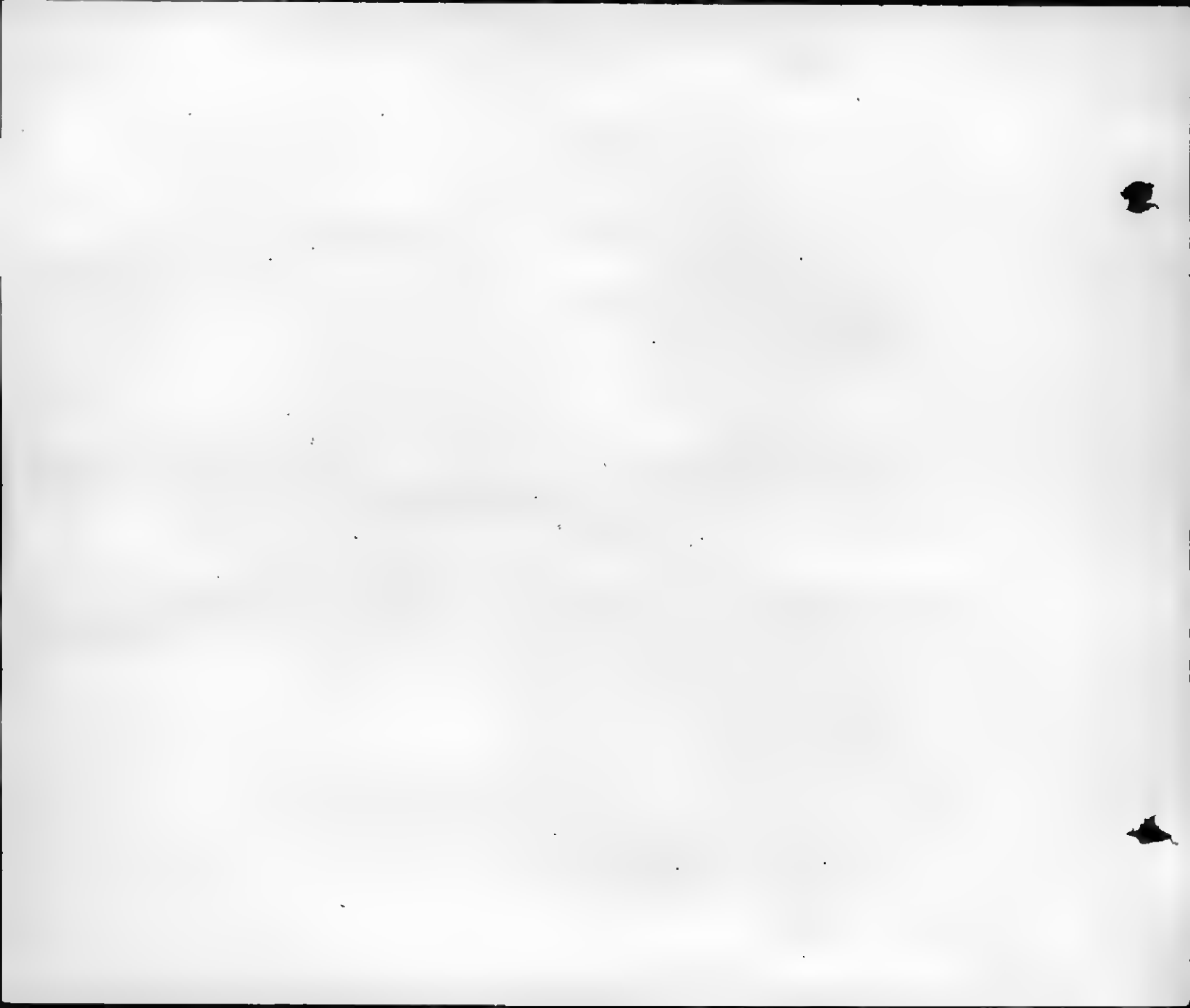
1306

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1291

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>3 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRUITLAND</u> d. STREET ADDRESS <u>1 MEADOW BRIDGE RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE BUTZ KEMMERER</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 23 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 31, 1904</u>	
9. AGE (In years last birthday) <u>56 yrs</u>		IF UNDER 1 YEAR: Months Days Hours Min		IF UNDER 24 HRS: Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Industrial</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLAYTON J. KEMMERER</u>				14. MOTHER'S MAIDEN NAME <u>EMMA BUTZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>162-09-1208</u>		17. INFORMANT Address <u>Mrs. Florence L. Kemmerer, Same.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis with left</u> <u>420.1</u> DUE TO <u>hemiplegia</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Posterior Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Cardiovascular Dis</u> (c) <u>(?)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>Jan 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 23, 1961</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Rufus S. Gardner</u>				22b. DATE SIGNED <u>1/23/61</u>		22c. PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER</u>	
22d. ADDRESS <u>PINE BLUFF RD, SALISBURY, MD.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-27-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Ambleton Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill + Johnson Co. Salisbury, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Robert L. Kenna</u>	

MEDICAL CERTIFICATION



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

1329

Reg. Dist. No.

1307

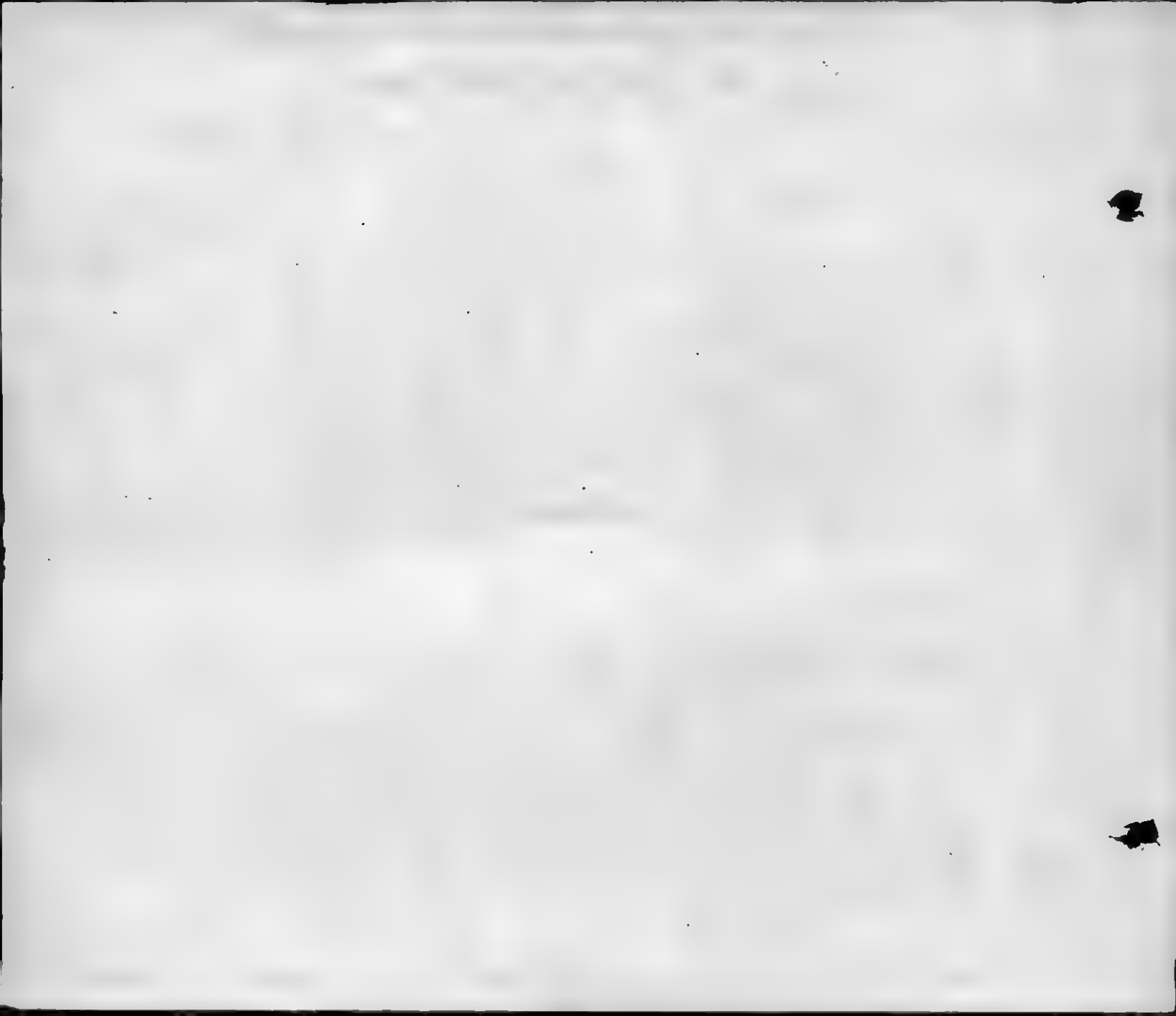
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY OR TOWN <u>Mardela</u>		LENGTH OF STAY (in this place) <u>1 mon.</u>		CITY OR TOWN <u>Rural - Mardela Springs</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maple Shade Connuement Home</u>				STREET ADDRESS <u>Bridge St.</u>		(If rural give location)	
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>Anna</u>		(Middle) <u>T</u>		(Last) <u>Larrimore</u>			
(Type or Print)							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>27 June 1891</u>	
						9. AGE last birthday <u>69</u> yrs.	
						IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John F Cheezum</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT'S ADDRESS <u>540 Nylon Blvd. Sea Ford - Del.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443 IMMEDIATE CAUSE (A) <u>Cerebro-vascular Hemorrhage L.F.T</u>				INTERVAL BETWEEN ONSET AND DEATH <u>< 1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>				<u>2 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis, generalized</u>				<u>10 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes</u>				<u>2 yrs</u>			
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>—</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>Oct 1960</u> , to <u>Jan 1961</u> , that I last saw the deceased alive on <u>28 Jan 1961</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Mary J. Larrimore</u>				DATE SIGNED <u>28 Jan 61</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				24. REC'D BY REGISTRAR			
DATE THEREOF <u>1/31/61</u>		NAME OF CEMETERY OR CREMATORY <u>Mardela Cemetery</u>		LOCATION (City, town, or county) <u>Mardela, Maryland</u>		(State)	
REGISTRAR'S SIGNATURE <u>C. S. K. K. K.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home</u>		ADDRESS <u>Shanptown, Md</u>			
DATE <u>FEB 1 '61</u>							



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

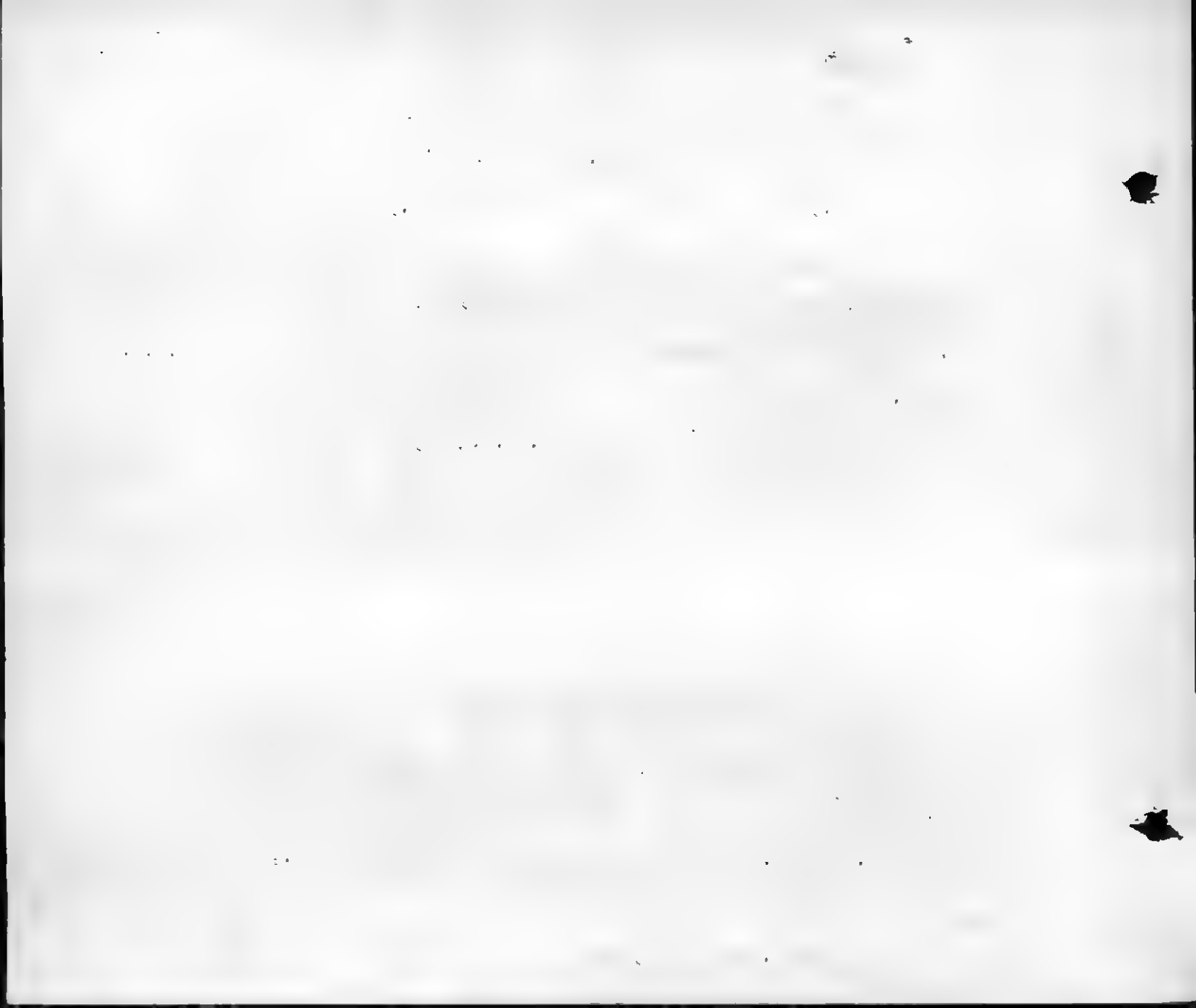
VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1308 Item 9 Film 6279 1-30-61 et 1293
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland c. LENGTH OF STAY IN 1b 8 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main St.,		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland d. STREET ADDRESS 1 Main St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUY Middle ELDRIDGE Last LONG		4. DATE OF DEATH Month 1 Day 14 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1883
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 11 Days 17 Hours 15 Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Wholesale	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Long		14. MOTHER'S MAIDEN NAME Cora Disharoon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-6959	
17. INFORMANT Mrs. G.E. Long, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 7 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12:45 19 61 to 1:14 19 61 , that (I) (we) last saw the deceased alive on 1.14 19 61 , and that death occurred at 7:45 AM, from the causes and on the date stated above.			
22a. SIGNATURE Fred R. Gramse		22b. DATE SIGNED 1/16/1961	
22c. PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse		22d. ADDRESS South Division St., Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/17/1961	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland		25a. REC'D BY REGISTRAR JAN 19 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Newman T. Baker



1309

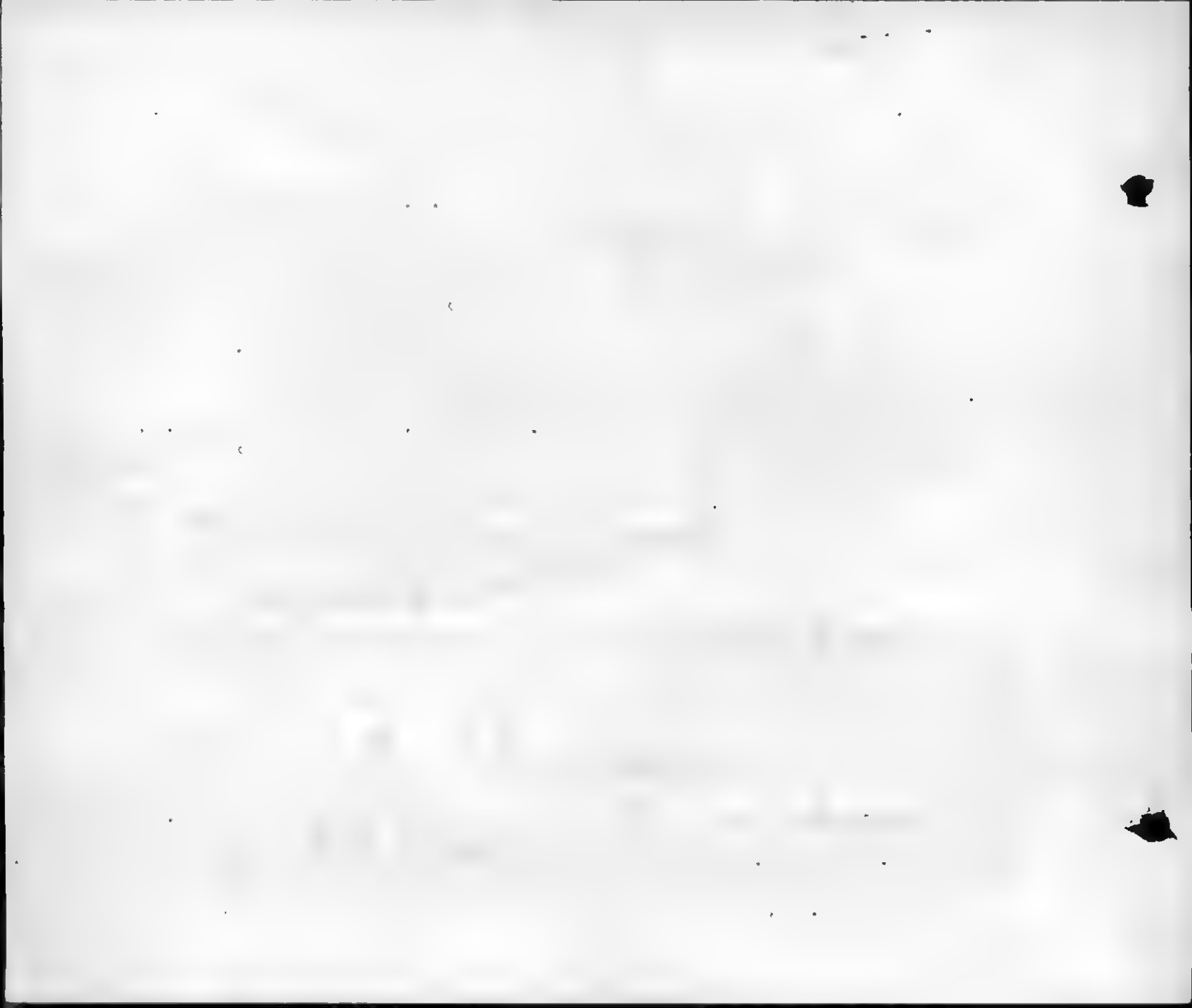
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1294

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b Salisbury		d. STREET ADDRESS R.D.# 4 Johnson Rd	
3. NAME OF DECEASED (Type or print) First Middle Last DAVID WAYNE messick		4. DATE OF DEATH Month Day Year January 19 - 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1954
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Salisbury (Hosp) Md.
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Arthur Amoss Messick	
14. MOTHER'S MAIDEN NAME Patricia Mary Tawes		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Arthur A. Messick (Father) R.D.#4 Johnson Rd Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular Collapse DUE TO (b) (Extreme Hyperpyrexia (Temp 108)) DUE TO (c) (? Sepsis ? Abnormality of Temperature Regulation)			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Med. History Congenital Cerebral Defect - Convulsive Disorder			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. N/A 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	20f. (City or town) (County) (State) N/A
21. I certify that (I) (this hospital) attended the deceased from 1/17 19 61 to 1/19 19 61 , that (I) (we) last saw the deceased alive on 1/19 19 61 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Alfred C Kolls		22b. DATE SIGNED Jan. 19, 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Alfred C. Kolls		22d. ADDRESS Medical Center, Salisbury Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 21, 1961	23c. NAME OF CEMETERY OR CREMATORY WICOMICO MEMORIAL PARK	23d. LOCATION (City, town, or county) (State) SALISBURY, MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR JAN 23 '61	
ADDRESS SALISBURY MARYLAND		25b. REGISTRAR'S SIGNATURE C. S. H. H. H.	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A18 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

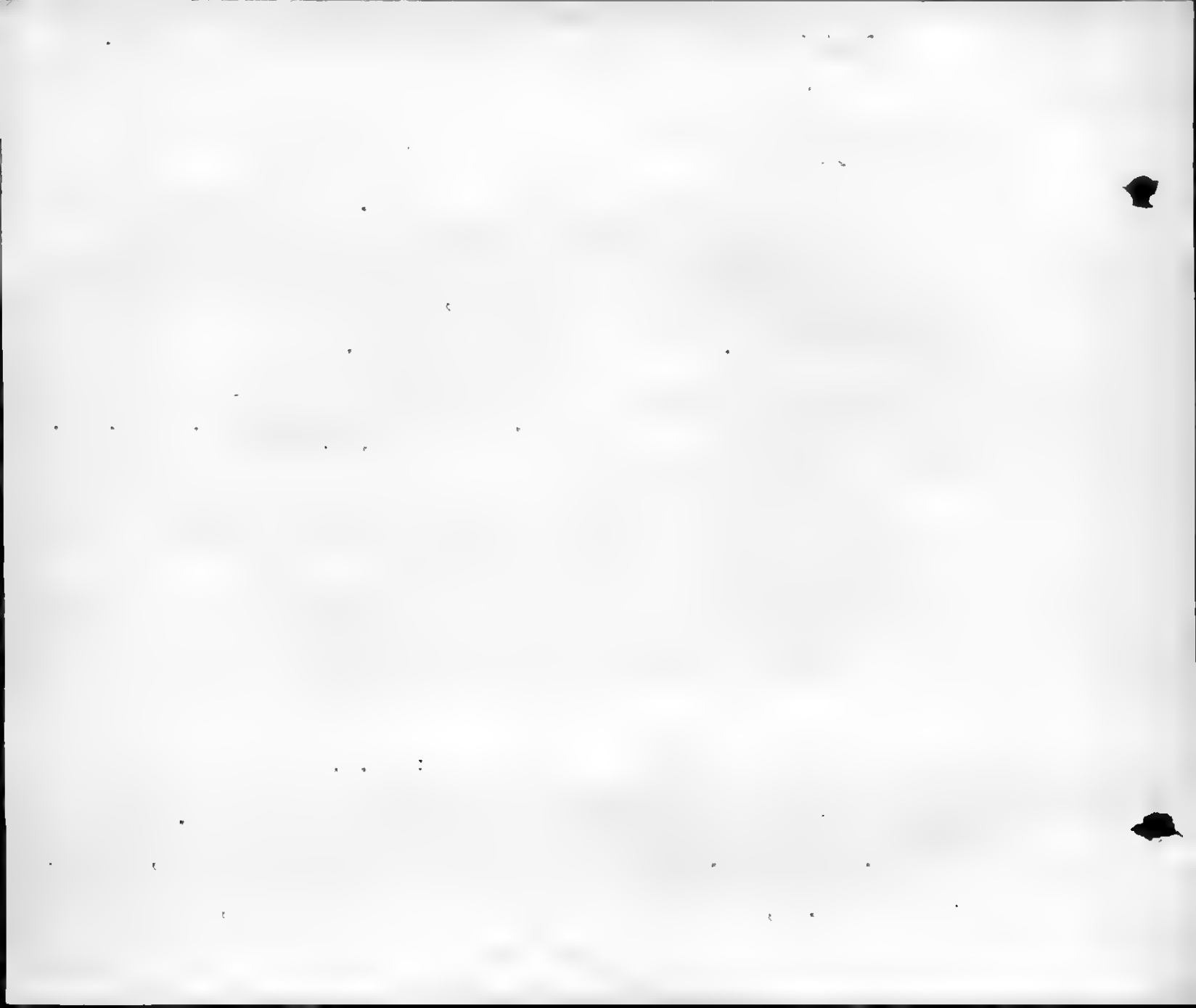
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1310

1295

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 221 West Philadelphia Ave		d. STREET ADDRESS 221 W. Philadelphia Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JEROME Middle RUFUS Last MILES		4. DATE OF DEATH Month JANUARY Day 14th Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1888
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 72 Days 14 Hours 14 Min 14	11. IF UNDER 24 HRS Months 72 Days 14 Hours 14 Min 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker at Baking Co.		10b. KIND OF BUSINESS OR INDUSTRY Baker	
11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel Miles		14. MOTHER'S MAIDEN NAME Hattie - - - - -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Katie Miles (Wife)		18. ADDRESS 221 W. Phila. Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 177X DUE TO Bronchopneumonia (b) Advanced Generalized Cerebral Palsy DUE TO 1 1/2 yrs. (c) lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a m N/A 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5:25 P.M. 19 1961 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 19 , from the causes and on the date stated above.			
22a. SIGNATURE William H. Fisher M.D.		22b. DATE SIGNED Jan. 18 / 1961	
22c. PHYSICIAN'S NAME (Type) Dr. William H. Fisher		22d. ADDRESS Medical Center Salisbury, Maryland	
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 18, 1961	
23c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY		23d. LOCATION (City, town, or county) (State) SALISBURY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR DATE JAN 19 '61	
ADDRESS SALISBURY MARYLAND		25b. REGISTRAR'S SIGNATURE Arthur L. King	



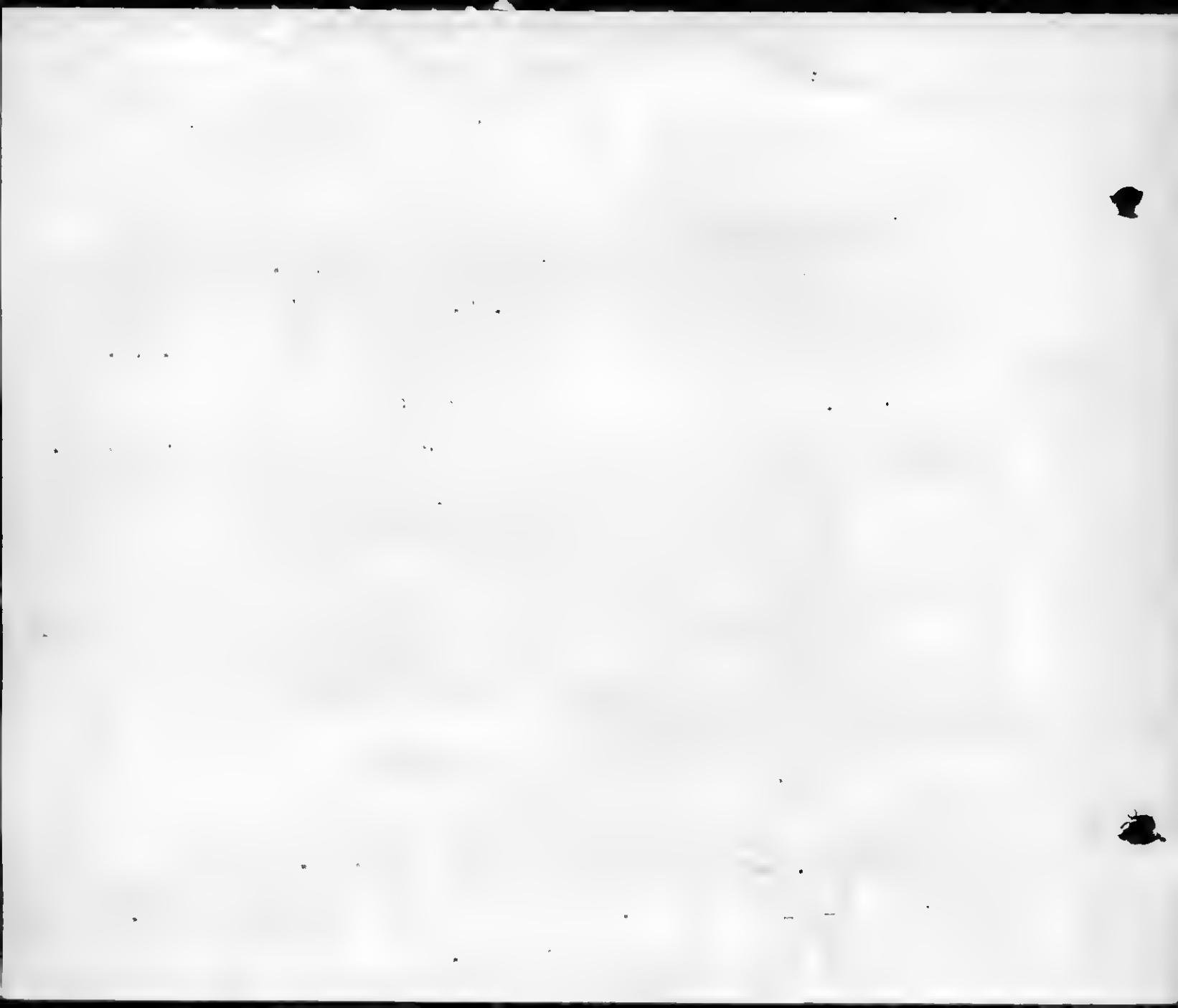
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1311

1296

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Scheneset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 8 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deers head Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ida Nelson Milligan		4. DATE OF DEATH Month Day Year Jan. 14 19 61	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1863
9. AGE (In years last birthday) 97 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel J. Nelson		14. MOTHER'S MAIDEN NAME Mary Bozman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Miss Kathryn Milligan		Address Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 7 da
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-17-1961 to 1-14-1961 , that (I) (we) last saw the deceased alive on 1-14-1961 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Lee L. Lawry		22b. DATE SIGNED 1-14-61	
22c. PHYSICIAN'S NAME (Type) Lee L. Lawry		22d. ADDRESS Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 1-16-61	23c. NAME OF CEMETERY OR CREMATORY St. Andrew Cemetery	23d. LOCATION (City, town, or county) (State) Princess Anne, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Levin P. Wilson		25a. REC'D BY REGISTRAR Princess Anne, Md.	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

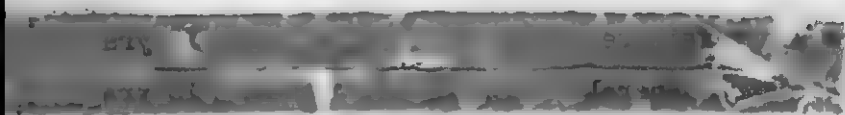
CERTIFICATE OF DEATH

Item 7 Film 6-1 2-15-61 et

1297

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN TB 102 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland		b. COUNTY Worcester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke		d. STREET ADDRESS 501 Cedar Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Steven Mitchell		4. DATE OF DEATH Jan. 27 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 15, 1887		9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail carrier	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alfred Mitchell		14. MOTHER'S MAIDEN NAME Mary Elizabeth Smith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 450.0		17. INFORMANT Alice Vincent		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Arteriosclerosis, general DUE TO (c) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None		20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Deer's Head Hospital; Salisbury, Md.		20f. (City or town) Salisbury		20g. (County) Worcester	
21. I certify that (this hospital) attended the deceased from Oct. 17, 1960 to Jan. 27, 1961 , that (I) (we) last saw the deceased alive on Jan. 26, 1961 , and that death occurred at 3:35 A.M. from the causes and on the date stated above.		22a. SIGNATURE Lee L. Lawry, M.D.		22b. DATE SIGNED 1/27/61		22c. PHYSICIAN'S NAME (Type) Lee L. Lawry, M.D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.		22e. REC'D BY REGISTRAR Arthur S. Kiana		22f. REGISTRAR'S SIGNATURE Arthur S. Kiana		22g. DATE FEB 2 '61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 31, 1961		23c. NAME OF CEMETERY OR CREMATORY Modest Town		23d. LOCATION (City, town or county) Modest Town		23e. (State) Va.		23f. FUNERAL DIRECTOR'S SIGNATURE Johnson Funeral Home		23g. ADDRESS Partly Va.		23h. DATE FEB 2 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

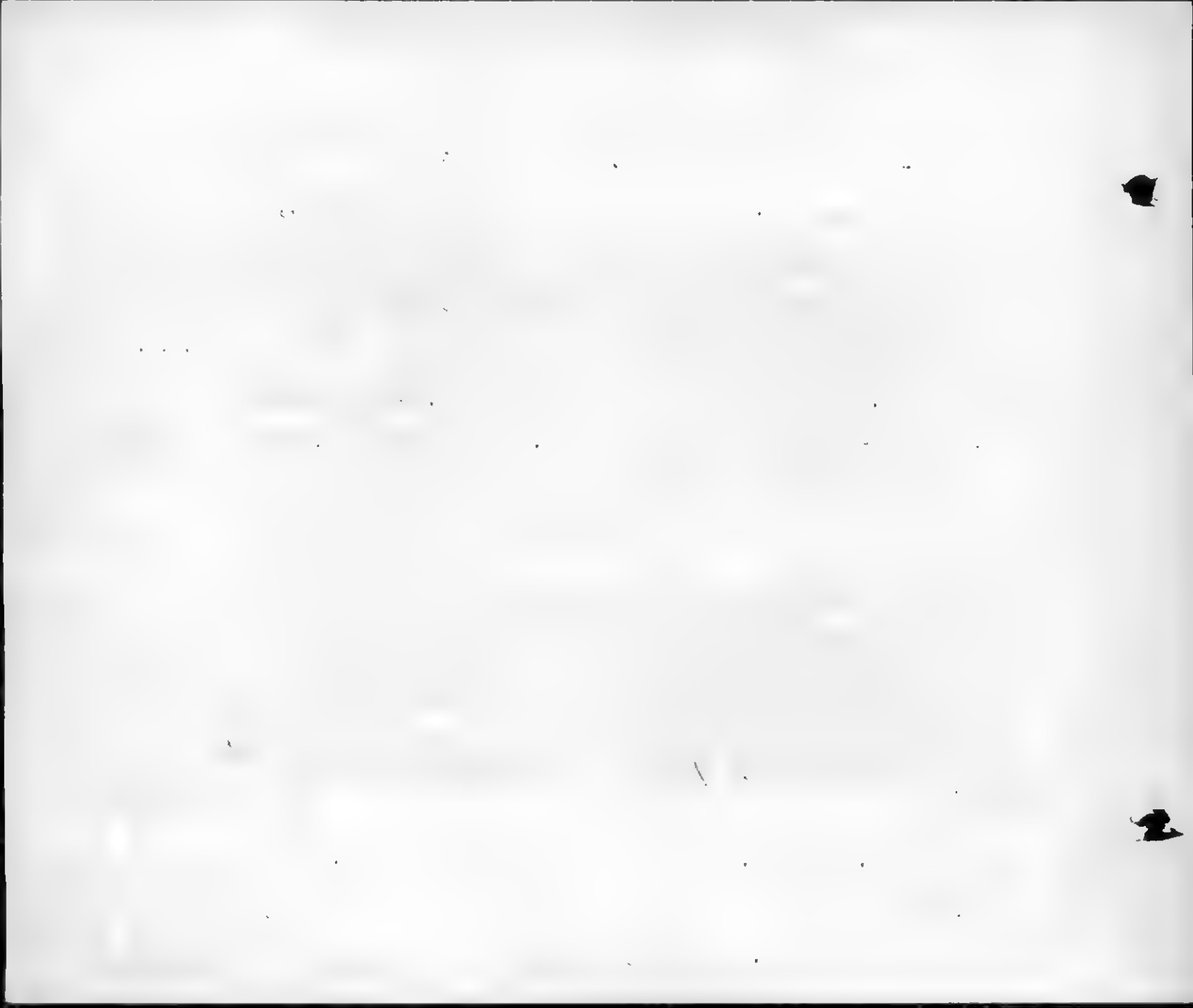
VR A15 (4)
15M 9/59

1313

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

(1298)

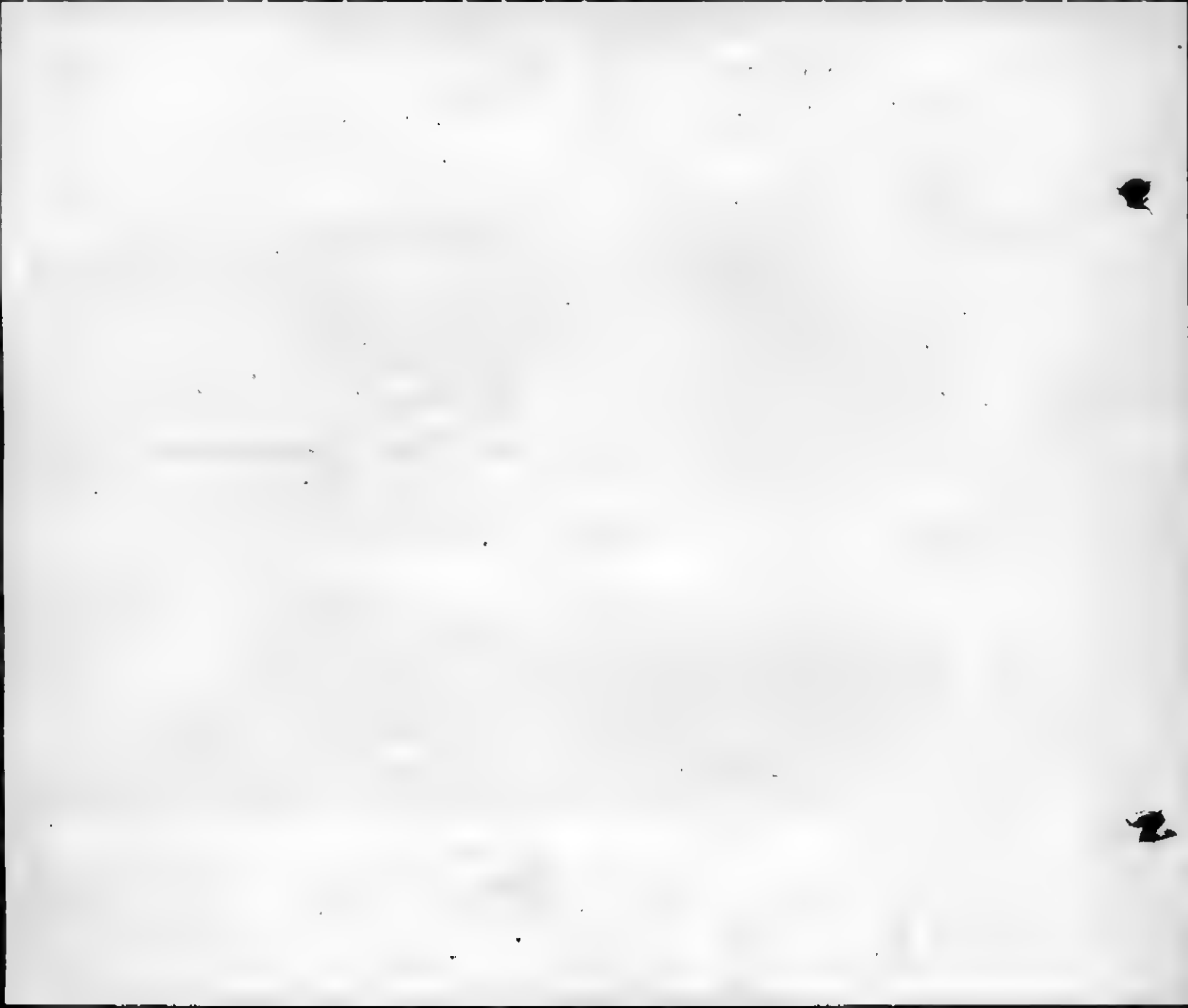
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>56 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ocean City Blvd.,</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CALVIN DURAND MORRIS</u>		4. DATE OF DEATH Month Day Year <u>1 21 1961</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>March 23, 1869</u>
9 AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Truck</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William R. Morris</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Maddox, Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mr. Linwood Morris, Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Cerebral</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>1-21</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-21</u> , 19 <u>61</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
22a SIGNATURE <u>Dr. Andrew C. Mitchell</u>		22b. DATE SIGNED <u>1/23/1961</u>	
22c PHYSICIAN'S NAME (Type) <u>Dr. Andrew C. Mitchell</u>		22d. ADDRESS <u>Maryland Ave., Salisbury, Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>1/24/61</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The Hill & Johnson Co. Salisbury, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 26 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>John E. K...</u>	



1315

(13.11)

1 PLACE OF DEATH a. COUNTY WICOMICO		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION DEER HEAD STATE HOSP.		d. STREET ADDRESS UNKNOWN 3V01-7	
3. NAME OF DECEASED (Type or print) Sidney J. Norris		4. DATE OF DEATH JAN 14 1961	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUG-19-1977
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. H. N. NORRIS		14. MOTHER'S MAIDEN NAME ELIZABETH WITHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-6531	
17. INFORMANT DEER HEAD HOSPITAL RECORDS MD		Address SALISBURY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Atherosclerosis 104.1 (c)			INTERVAL BETWEEN ONSET AND DEATH 2 hrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS ALTPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 8, 1960 to Jan 14, 1961 , that (I) (we) last saw the deceased alive on Jan 14, 1961 , and that death occurred at 1:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE L. S. Laury		22b. DATE SIGNED 1-14-61	
22c. PHYSICIAN'S NAME (Type) L. S. Laury		22d. ADDRESS SALISBURY - MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-17-1961	23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S HUNTINGDON	23d. LOCATION (City, town, or county) (State) Baltimore Md
24. FUNERAL DIRECTOR'S SIGNATURE L. S. Laury		25a. REC'D BY REGISTRAR JAN 19 1961	
ADDRESS Primer Ave		25b. REGISTRAR'S SIGNATURE Art - J. H. N.	



1314

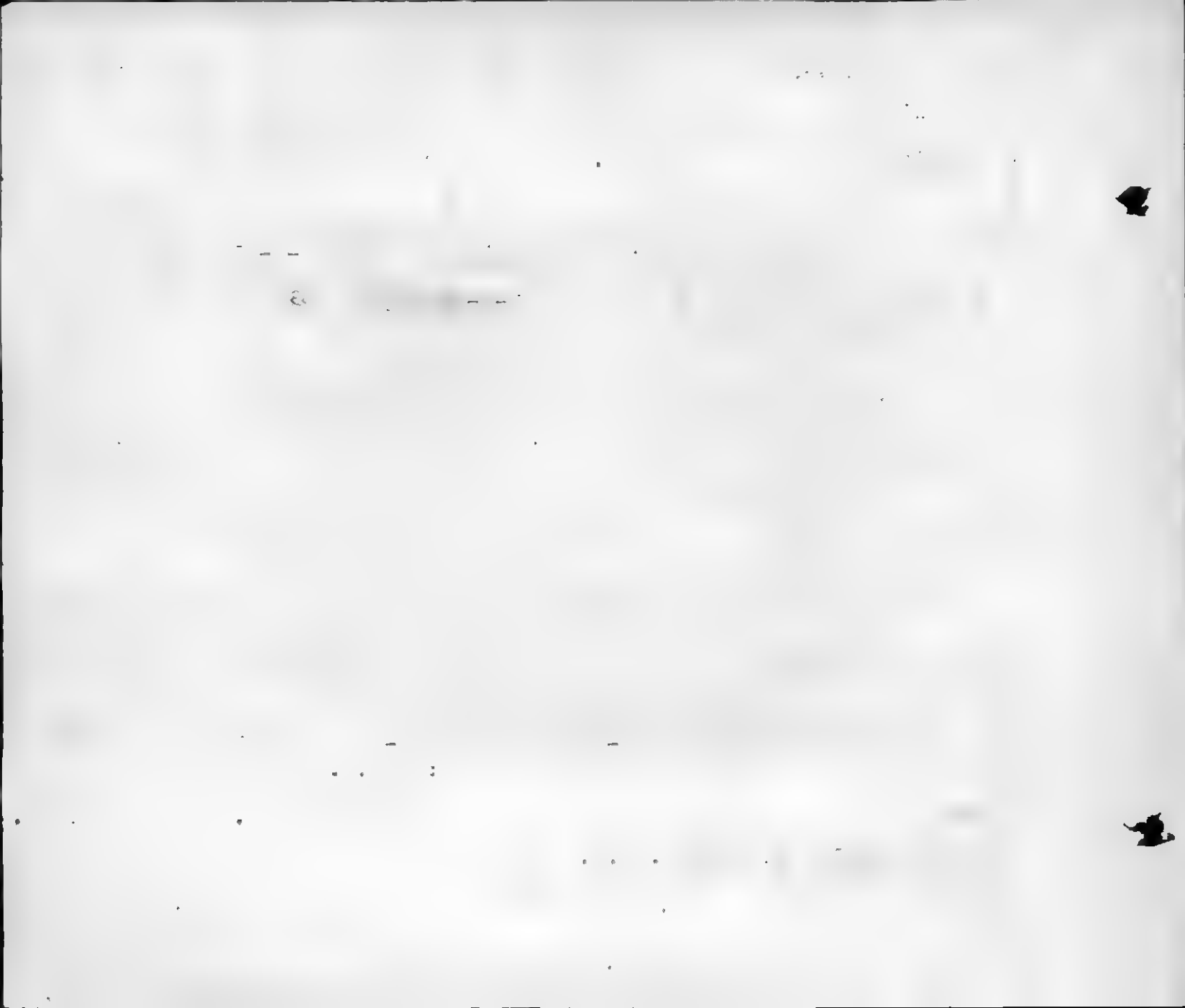
CERTIFICATE OF DEATH

Reg. Dist. No. 1290

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Watters Morrison		4. DATE OF DEATH Month Day Year 1-8-61 19 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William J. H. Watters		14. MOTHER'S MAIDEN NAME Mary Louise Nicodemus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		17. INFORMANT Address Mrs. Gerald A. Lee, RFD, Marion Station, Md.	
16. SOCIAL SECURITY NO. None		12. CITIZEN OF WHAT COUNTRY? USA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-30 , 19 58 , to 1-8 , 19 61 , that I last saw the deceased alive on 1-4 , 19 61 , and that death occurred at 9:40 A.M. the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 116 East Main St., Salisbury, Md.			
ACTUAL SIGNATURE Philip A. Insley M.D.		PHYSICIAN'S NAME (Type) Philip A. Insley, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/10/61	22c. NAME OF CEMETERY OR CREMATORY St. Paul's Episcopal	22d. LOCATION (City, town, or county) (State) Marion Station, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons		24a. REC'D BY REGISTRAR DATE JAN 11 '61	
24b. REGISTRAR'S SIGNATURE Crisfield, Md.		24c. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 FOR STATE HEALTH DEPT.

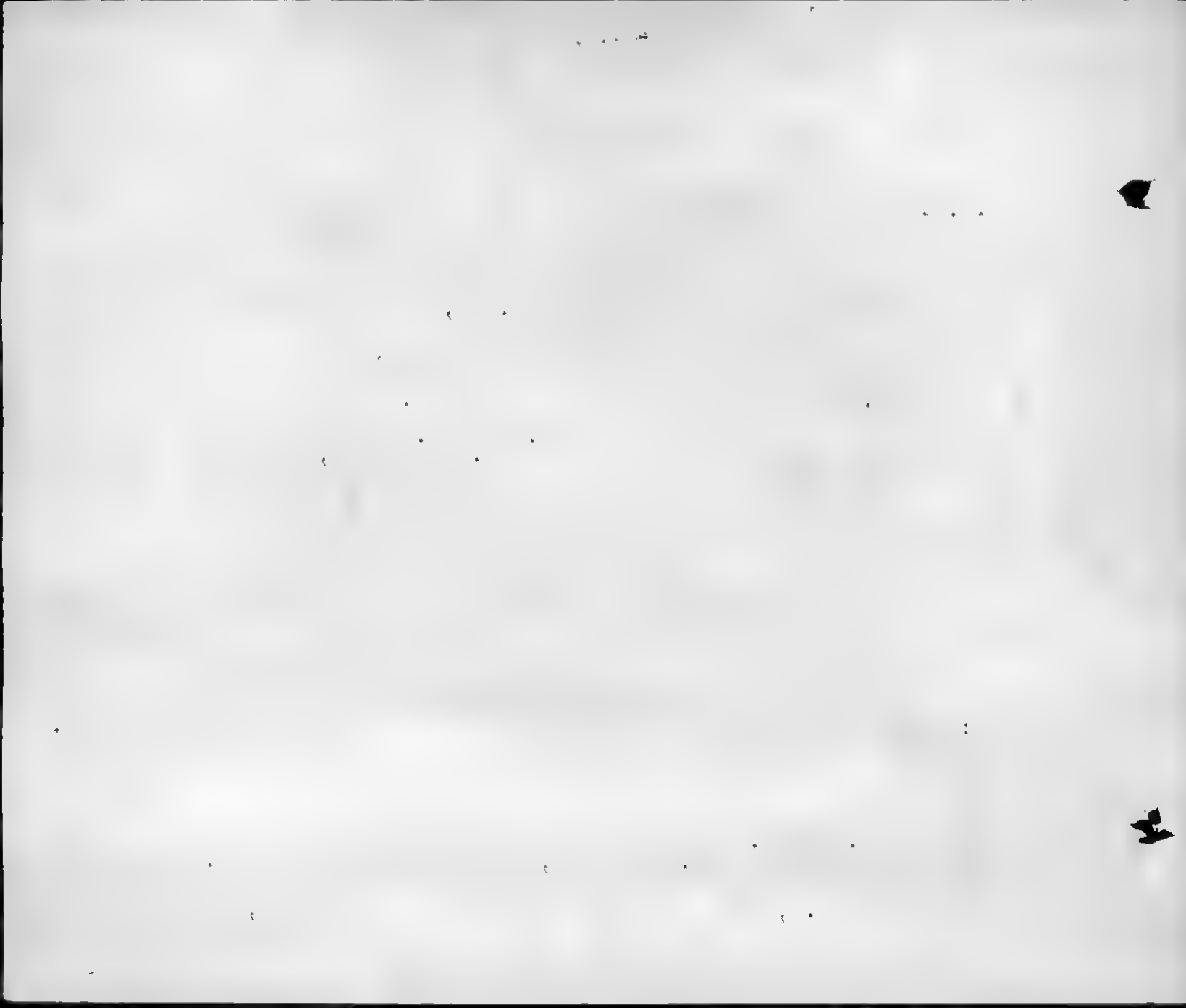
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deaths necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
1310 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if inst. tuition; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				
c. LENGTH OF STAY IN <u>11</u>					d. STREET ADDRESS <u>625 Fitzwater St</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D.O.A. Pen Gen Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>ALINE LAURA PATRICK</u>					4. DATE OF DEATH <u>JANUARY 1st 19 61</u>				
5. SEX <u>Female</u>					6. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS. last birthday) <u>32</u> yrs. <u>1</u> month <u>1</u> day <u>1</u> hour <u>1</u> min.				
6. COLOR OR RACE <u>White</u>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>				
8. DATE OF BIRTH <u>Oct. 15, 1928</u>					9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS. last birthday) <u>32</u> yrs. <u>1</u> month <u>1</u> day <u>1</u> hour <u>1</u> min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work & Hospital Attendant</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, Maryland</u>				
11. BIRTHPLACE (State or foreign country) <u>U S A</u>					12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>				
13. FATHER'S NAME <u>George W. Truitt</u>					14. MOTHER'S MAIDEN NAME <u>Laura B. Smith</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>Mrs. Laura B. Truitt (Mother)</u>				
17. INFORMANT <u>625 Fitzwater St. Salisbury, Maryland</u>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound of Brain</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>976</u>					DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self</u>				
20c. TIME OF INJURY Month, Day, Year <u>1:00 a.m. 1/1 1961</u>					20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>At Home</u>					20f. (City or town) <u>Salisbury (Wicomico) Md.</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>407 Camden Ave. Salisbury, Md</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DATE SIGNED <u>Jan. 3rd /1961</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>Jan. 4, 1961</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>					22d. LOCATION (City, town, or country) (State) <u>Salisbury, Maryland</u>				
23. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>					ADDRESS <u>SALISBURY MARYLAND</u>				
24a. REC'D BY REGISTRAR <u>JAN 5 '61</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1317 Item 7 Film 279 1-16-61 et
CERTIFICATE OF DEATH
1302

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN TB <u>141 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> d. STREET ADDRESS <u>605 Dover Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Perkins</u> Last <u>Perkins</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEV <input type="checkbox"/> MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>3-25-</u> WIDOWED <input checked="" type="checkbox"/> D. VORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>57 yrs.</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Convalescent Home Nurse Aid</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> 13. FATHER'S NAME <u>James Green</u> 14. MOTHER'S MAIDEN NAME <u>Nannie Bailey</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Catherine Smith, Easton, Md.</u> Address <u>—</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> +20 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Myocardial infarction</u> DUE TO (c) <u>Severe Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> recent ?		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>August 15, 1960</u> Hour a.m. <u>1:40 P</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from... <u>August 15, 1960</u> to <u>Jan. 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan. 3, 1961</u> , and that death occurred at <u>1:40 P</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>V. Juerman</u> 22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u> 22d. ADDRESS <u>Deer's Head Hospital; Salisbury, Md.</u> 22e. REC'D BY REGISTRAR <u>—</u> 22f. REGISTRAR'S SIGNATURE <u>—</u> 22g. DATE <u>JAN 10 '61</u> 22h. REGISTRAR'S SIGNATURE <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>1-7-60</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Richards Bur.</u> 23d. LOCATION (City, town or county) (State) <u>Easton Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Schell, Easton, Md.</u> 25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>—</u> 25c. DATE <u>JAN 10 '61</u> 25d. REGISTRAR'S SIGNATURE <u>—</u>	



1318

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

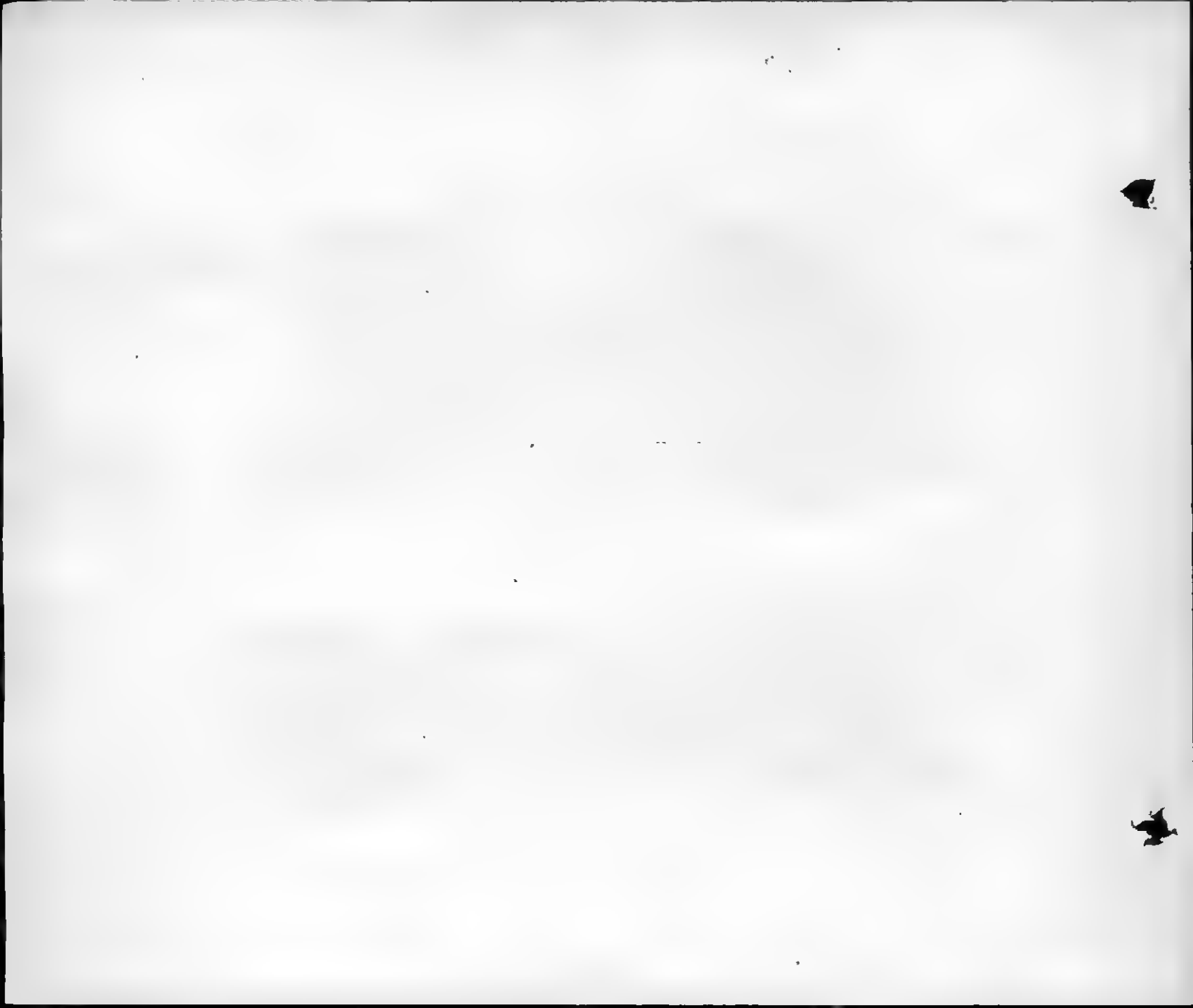
CERTIFICATE OF DEATH

1313

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 6 Wks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. STREET ADDRESS Hebron			
3. NAME OF DECEASED (Type or print) First NELLIE Middle WALTER Last PHILLIPS				4. DATE OF DEATH Month 1 Day 31 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1889		9. AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David I Webster				14. MOTHER'S MAIDEN NAME Emma Graham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-09-2164		17. INFORMANT Mr. William Walter, Hebron			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) CARCINOMATOSIS (SITE UN-DETERMINED) (c) DETERMINED						INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 9 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/10 1961, to 1/31 1961, that (I) (we) last saw the deceased alive on 1/21 1961, and that death occurred at 2A M. from the causes and on the date stated above							
22a. SIGNATURE John M. Bloxom III				22b. DATE SIGNED 2-2-1961			
22c. PHYSICIAN'S NAME (Type) JOHN M. BLOXOM III				22d. ADDRESS MEDICAL CENTER, SALISBURY, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2- -1961		23c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery		23d. LOCATION (City, town, or county) (State) Hebron, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				25a. REC'D BY REGISTRAR FEB 3 '61		25b. REGISTRAR'S SIGNATURE C. J. L. Kline	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1364

1319

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELA</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GEORGETOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>5 N. RACE ST</u>			
3. NAME OF DECEASED (Type or print) <u>ALEINE HILYARD ROYAL</u>				4. DATE OF DEATH <u>JANUARY 4 1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 Mar 98 62</u> yrs		9. AGE (In years lost birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housew. fe</u>		11. BIRTHPLACE (State or foreign country) <u>DELA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Walter B. Hilyard</u>				14. MOTHER'S MAIDEN NAME <u>Cora Toulson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>none</u>		17. INFORMANT <u>Thayer L. Royal</u> Address <u>GEORGETOWN DELA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diabetic nephropathy</u>							
2.60 X DUE TO <u>Anasarca due to (1) kidney failure</u>						2-3 years	
Conditions, if any which gave rise to immediate cause (c), stating the underlying cause lost. <u>(2) heart failure</u>						7 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - advanced arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1960</u> to <u>Jan 4 1961</u> , that (I) was last saw the deceased alive on <u>4 Jan</u> 1961, and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Joseph C. Fitzgerald</u>	
22d. ADDRESS <u>707 Camden Avenue</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7 JAN 61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST Pauls</u>		23d. LOCATION (City, town, or county) (State) <u>GEORGETOWN DELA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald F. Dard</u>				25a. REC'D BY REGISTRAR <u>Jan 9 '61</u>		25b. REGISTRAR'S SIGNATURE	



TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

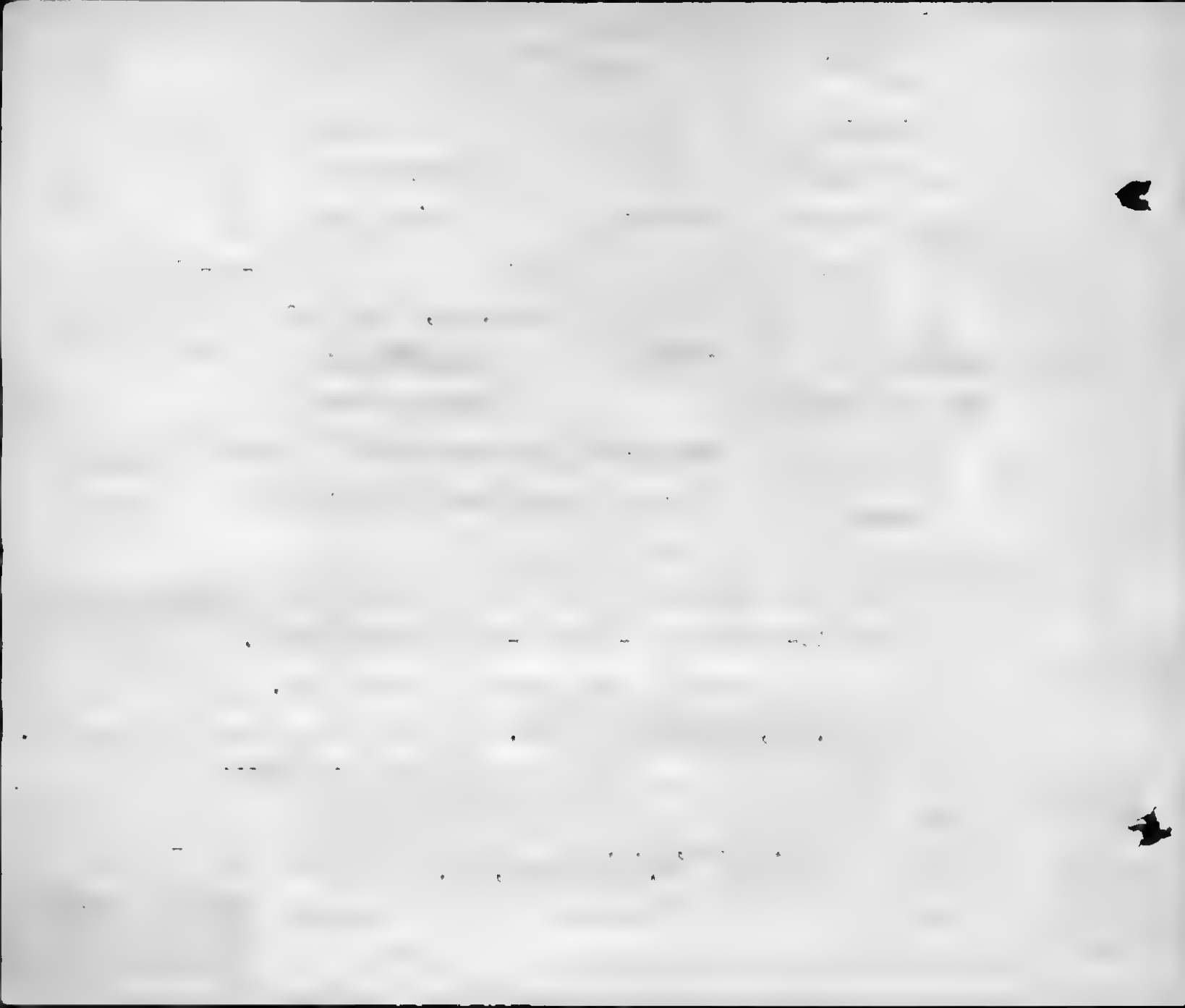
1
FOR STATE
HEALTH DEPT.

(M)

(1)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1320 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1305											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>				b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town <u>Salisbury</u>				c. LENGTH OF STAY in 1b <u>2YR 5 MOS</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deers Head State Hospital</u>				d. STREET ADDRESS <u>Route # 3</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eugene W Scott</u>				4. DATE OF DEATH <u>1-13-61</u>				19			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 15, 1929</u>		9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 24 HRS. Hours Min.			
13. FATHER'S NAME <u>Samuel Scott</u>				14. MOTHER'S MAIDEN NAME <u>Annie Scott</u>				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>226-267066</u>				17. INFORMANT <u>Jene Scott, Queenstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434-1</u> DUE TO <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>434-1</u> DUE TO <u>Acute congestive heart failure</u> (c) <u>434-1</u> DUE TO <u>Acute congestive heart failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434-1</u> DUE TO <u>Acute congestive heart failure</u> (b) <u>434-1</u> DUE TO <u>Acute congestive heart failure</u> (c) <u>434-1</u> DUE TO <u>Acute congestive heart failure</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Quadruplegic- Fracture C-5 and C-6 with cord injury.</u> <u>Thrown by hay loader on Clark Farm.</u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>Aug. 12, 1958</u> p.m. <u>1958</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm.</u>			
20f. (City or town) <u>Centerville</u>				20g. (County) <u>Queen Anne Md.</u>				20h. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ADDRESS (Street, city, town, or county) <u>107 Camden Ave., Salisbury, Md.</u>				1-16-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-17-61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>CARMICHAEL Cem</u>			
22d. LOCATION (City, town, or county) <u>Queenstown, Md.</u>				22e. (State) <u>Md.</u>				22f. (Country) <u>U.S.A.</u>			
23. FUNERAL DIRECTOR <u>James D. Shill, Porton, Md.</u>				ADDRESS <u>Porton, Md.</u>				24a. REC'D BY REGISTRAR <u>Jan 18 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				24c. (City, town, or county) <u>Porton, Md.</u>				24d. (State) <u>Md.</u>			



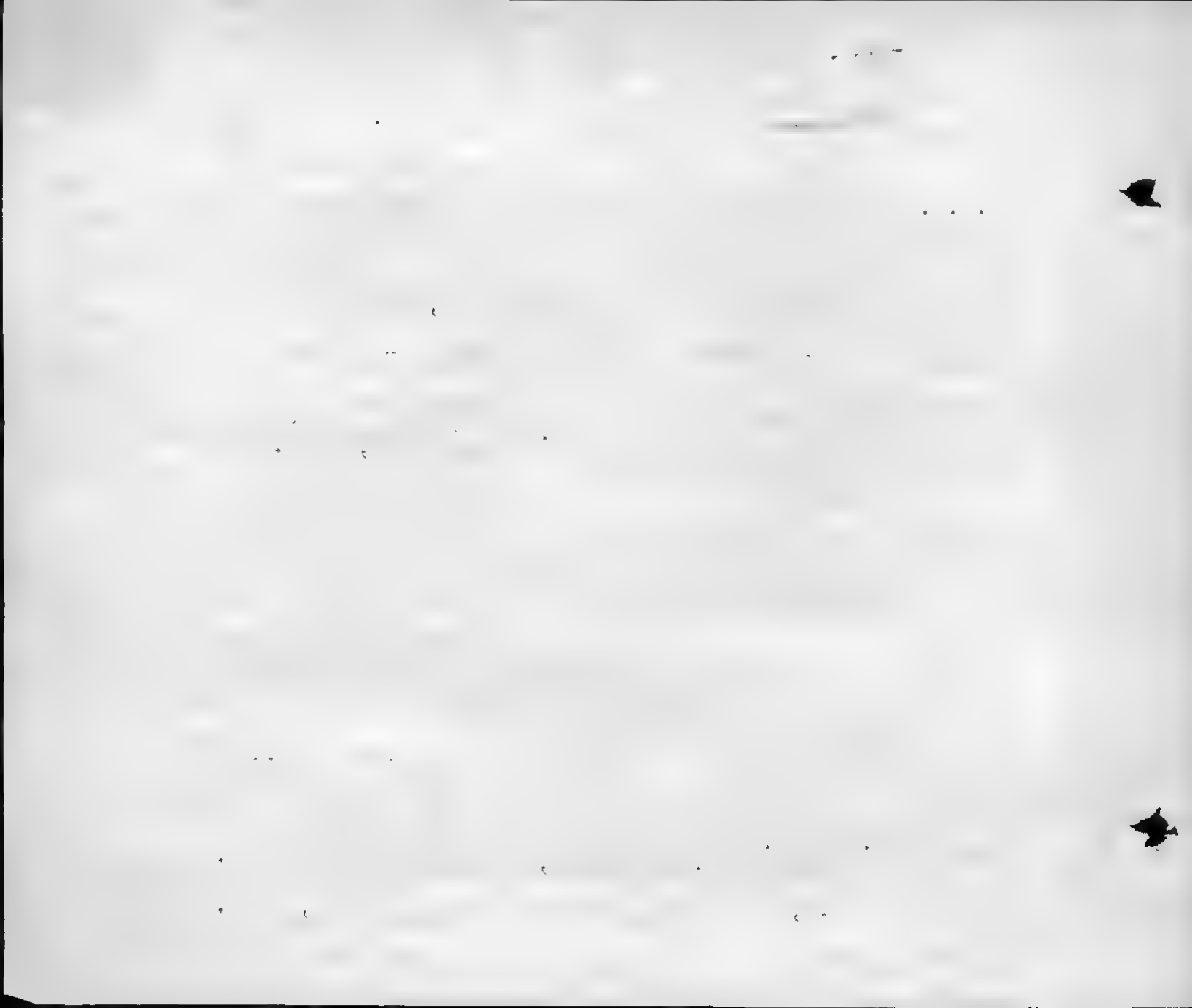
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
1321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Mass.</u> b. COUNTY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salt Framingham</u>		d. STREET ADDRESS <u>Edgell Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>4th</u> Year <u>1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D.O.A. Pen Gen Hospital</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>DIVORCED</u> <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1913</u>		9. AGE (In years last birthday) <u>47</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
13. NAME OF DECEASED (Type or print) <u>VINCENT</u>		11. BIRTHPLACE (State or foreign country) <u>Voskotoja-Albania</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13. FATHER'S NAME <u>Louis Chkliwe</u>		14. MOTHER'S MAIDEN NAME <u>Lenora Kristo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Arthur Sellow (Son)</u> <u>Framingham, Mass.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage midbrain spontaneous</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio sclerosis</u> (c) <u> </u> DUE TO (e), stating the underlying cause last. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Natick, Mass.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. Earl L. Royer</u>		407 Camden Ave. Salisbury, Md		Address (Street, city, town, or county)		DATE SIGNED <u>Jan. 5 / 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 9, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dell Park Cemetery</u>		22d. LOCATION (City, town, or country) <u>Natick, Mass.</u>		(State)	
23. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Kruse</u>			



CERTIFICATE OF DEATH

Reg. Dist. No. 61307

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marion Middle Beaven Last Sherwood		4. DATE OF DEATH Month Jan. Day 14th Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1888
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 14 Hours 19 Min.	IF UNDER 24 HRS. Months 72 Days 14 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Sherwood		14. MOTHER'S MAIDEN NAME Charlotte Fleetwood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 716-01-9444	
17. INFORMANT Ethel Sherwood, Delmar, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion, acute DUE TO Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus - small laceration occiput.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1955 to Jan 14, 1961 , that I last saw the deceased alive on Jan 13, 1961 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 303 East Street, Delmar, Md. DATE SIGNED 1-17-61			
ACTUAL SIGNATURE Dr. L.V. Sohler		M.D. 303 East Street, Delmar, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-18-61	22c. NAME OF CEMETERY OR CREMATORY Mount Olive	22d. LOCATION (City, town, or county) (State) Delmar, Del.
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Gammel Co. - Delmar, Del.		24a. REC'D BY REGISTRAR DATE JAN 20 '61	
24b. REGISTRAR'S SIGNATURE W. S. Gammel			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



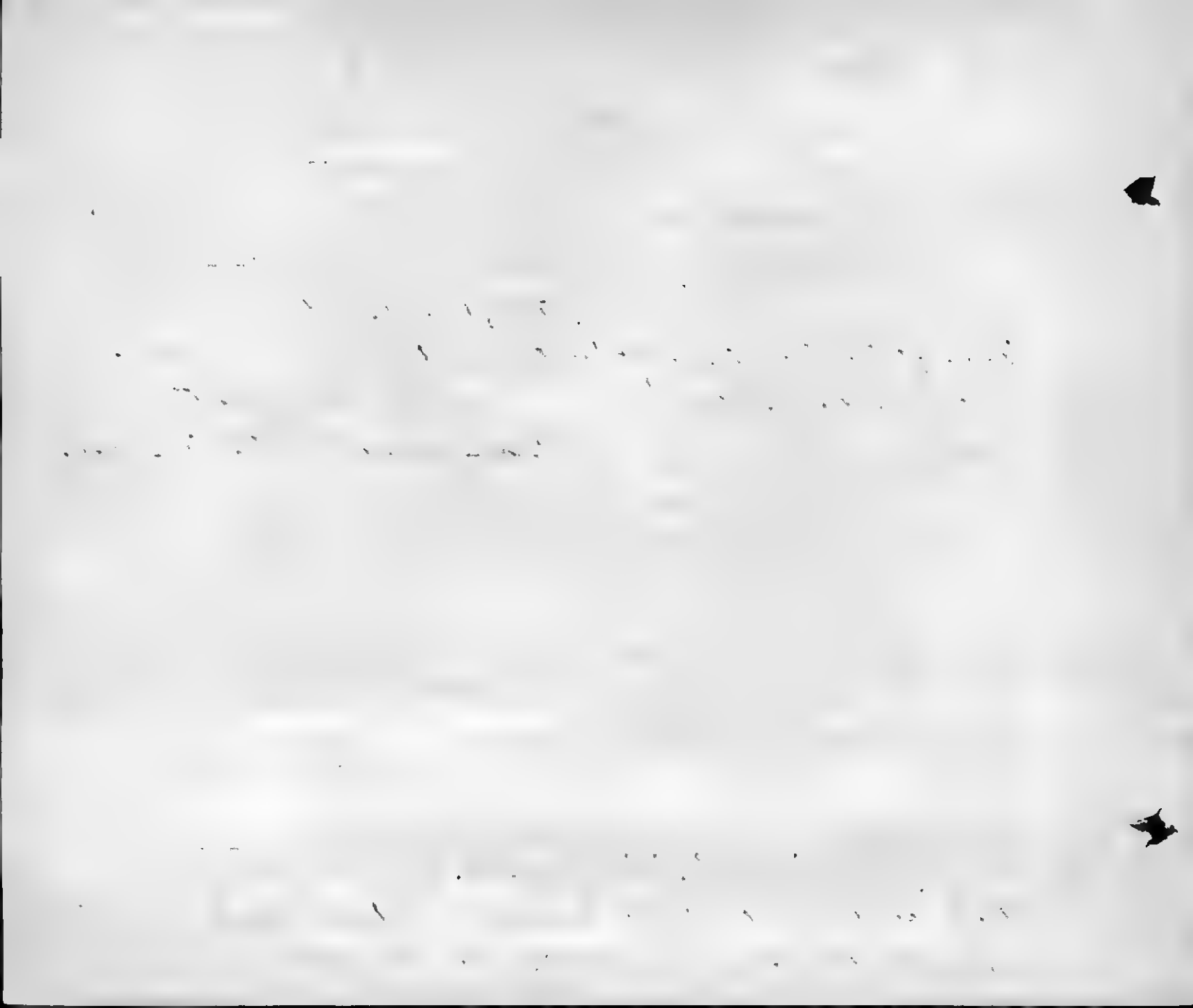
1 FOR STATE HEALTH DEPT.

THIS MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1323 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1318

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Pittsville	
3. NAME OF DECEASED (Type or print) Otto H Short		4. DATE OF DEATH Month 1 Day 2 Year 61	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming + Painter		10b. KIND OF BUSINESS OR INDUSTRY Farming + Painter	
13. FATHER'S NAME James M. Short		14. MOTHER'S MAIDEN NAME Evelyn A. West	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. Grace Short - Pittsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1/5/61		22b. DATE THEREOF 1/5/61	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Pittsville Md.	
23. FUNERAL DIRECTOR Ronald James Millatow, Del.		24a. REC'D BY REGISTRAR DATE JAN 9 '61	
ADDRESS Pittsville, Md.		24b. REGISTRAR'S SIGNATURE Charles L. Howard	



1
FOR STATE
HEALTH DEPT.

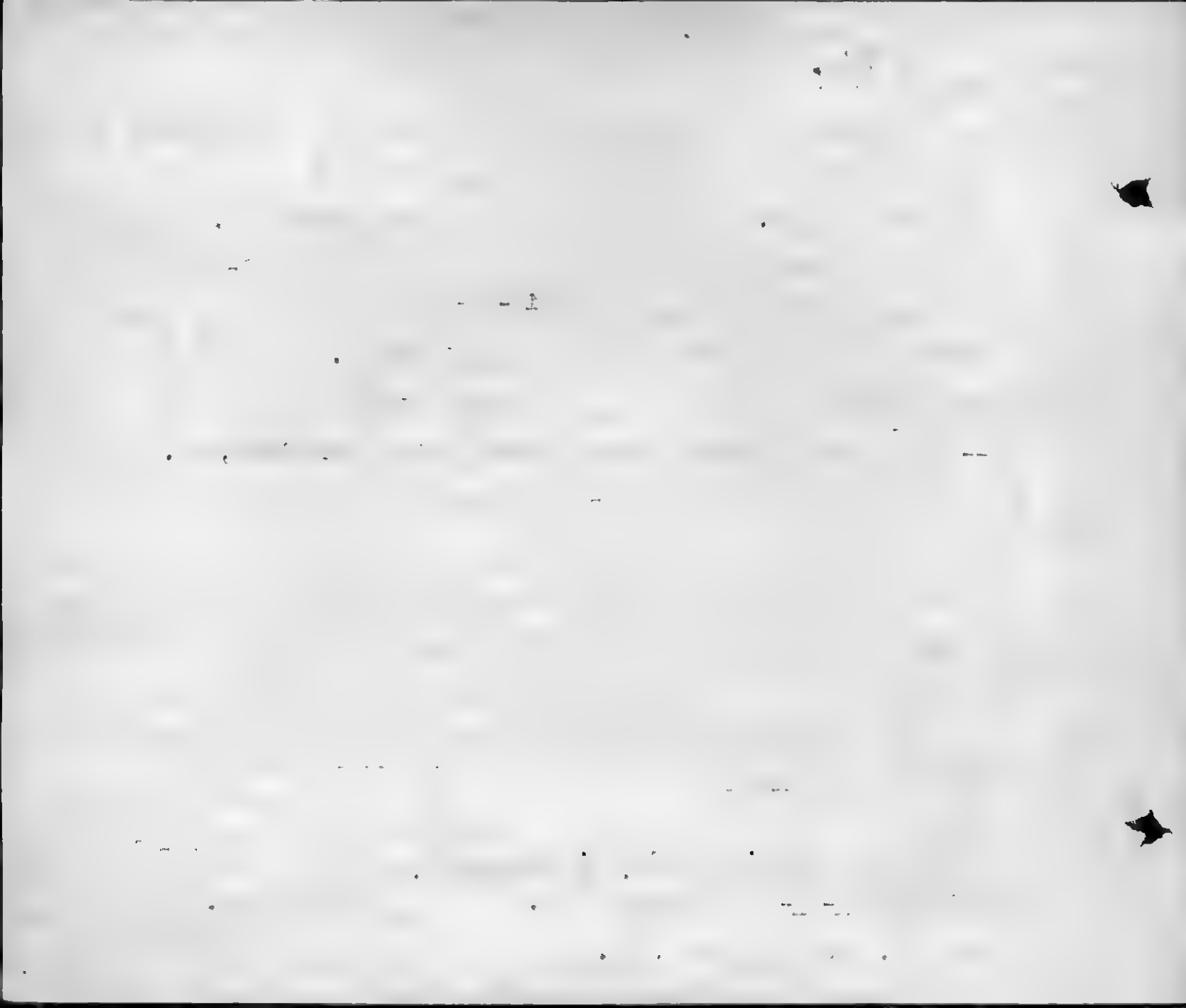
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Health Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND			
1324 MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
64309			
1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury	
c. LENGTH OF STAY IN TB		d. STREET ADDRESS Fitzwater St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fitzwater St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Jean Smith		4. DATE OF DEATH 1-3-61	
5. SEX F		6. COLOR OR RACE C	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12-30-60	
9. AGE (In years last birthday) 1 yrs. 3 months 3 days 19 hours 0 min.		10. AGE (In years last birthday) 1 yrs. 3 months 3 days 19 hours 0 min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Wicimico co.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Smith		14. MOTHER'S MAIDEN NAME Emma Evans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) none		16. SOCIAL SECURITY NO. Emma Smith Salisbury, Md.	
17. INFORMANT Emma Smith Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4491X IMMEDIATE CAUSE (a) Broncho-pneumonia- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1-5-61 ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF I-6-61 22c. NAME OF CEMETERY OR CREMATORY Houston cem. 22d. LOCATION (City, town, or country) (State) Salisbury, Md. 23. FUNERAL DIRECTOR Booker M. West Salisbury, Md. ADDRESS 24a. REC'D BY REGISTRAR JAN 11 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

INTERVAL BETWEEN ONSET AND DEATH
Hours



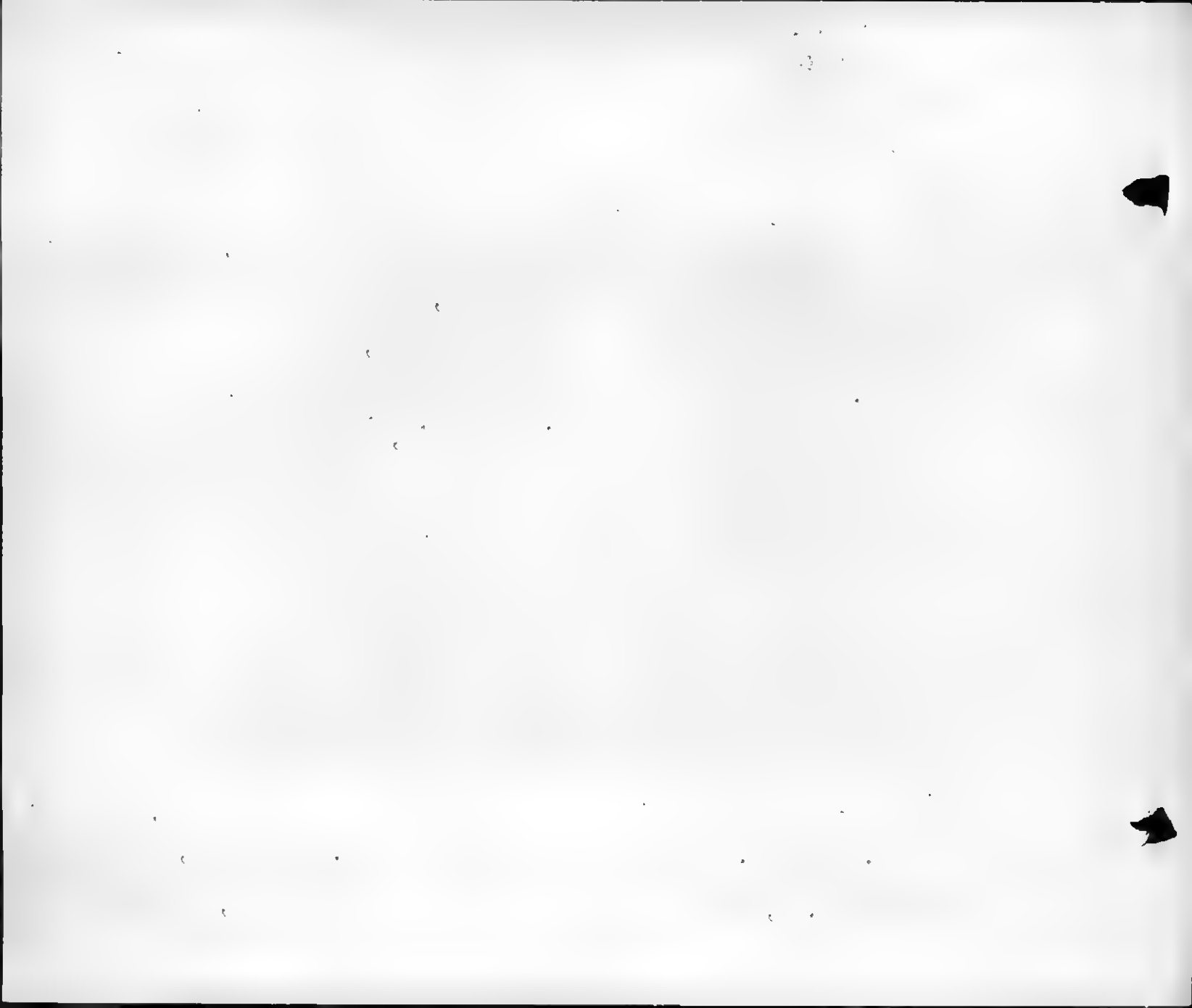
1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1310

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium		d. STREET ADDRESS 604 Monroe St	
3. NAME OF DECEASED (Type or print) FLORENCE MAY STATON		4. DATE OF DEATH JAN. 15th 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1901
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR: Months 5 Days 10 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- House Keeper		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Fruitland, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel M. Banks		14. MOTHER'S MAIDEN NAME Emma Jane Richardson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. George E. Staton (Husband)	
17. ADDRESS 604 Monroe St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 260x DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last, (b) Diabetic Insulin DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A 19 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from 6-3-55 to 1-13-61 , that (I) (we) last saw the deceased alive on 1-13-61 , and that death occurred at 1:25 P.M. from the causes and on the date stated above			
22a. SIGNATURE Dr. Andrew C. Mitchell		22b. DATE SIGNED Jan. 16 1961	
22c. PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell		22d. ADDRESS Maryland Ave. Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 18, 1961	
23c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY		23d. LOCATION (City, town, or county) (State) SALISBURY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR DATE JAN 18 '61	
ADDRESS SALISBURY MARYLAND		25b. REGISTRAR'S SIGNATURE C. S. H. H. H.	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

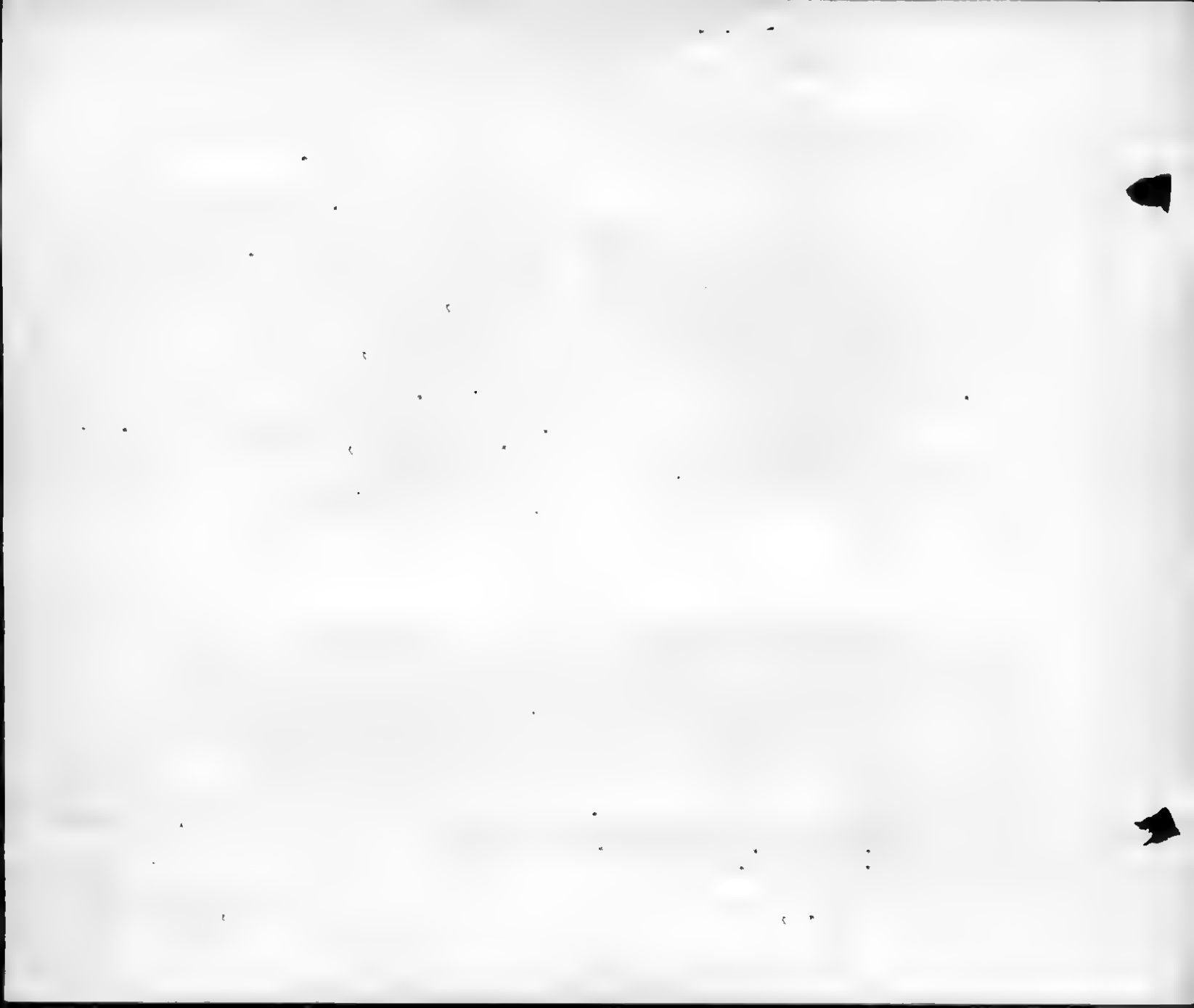
1326

1326

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

61311

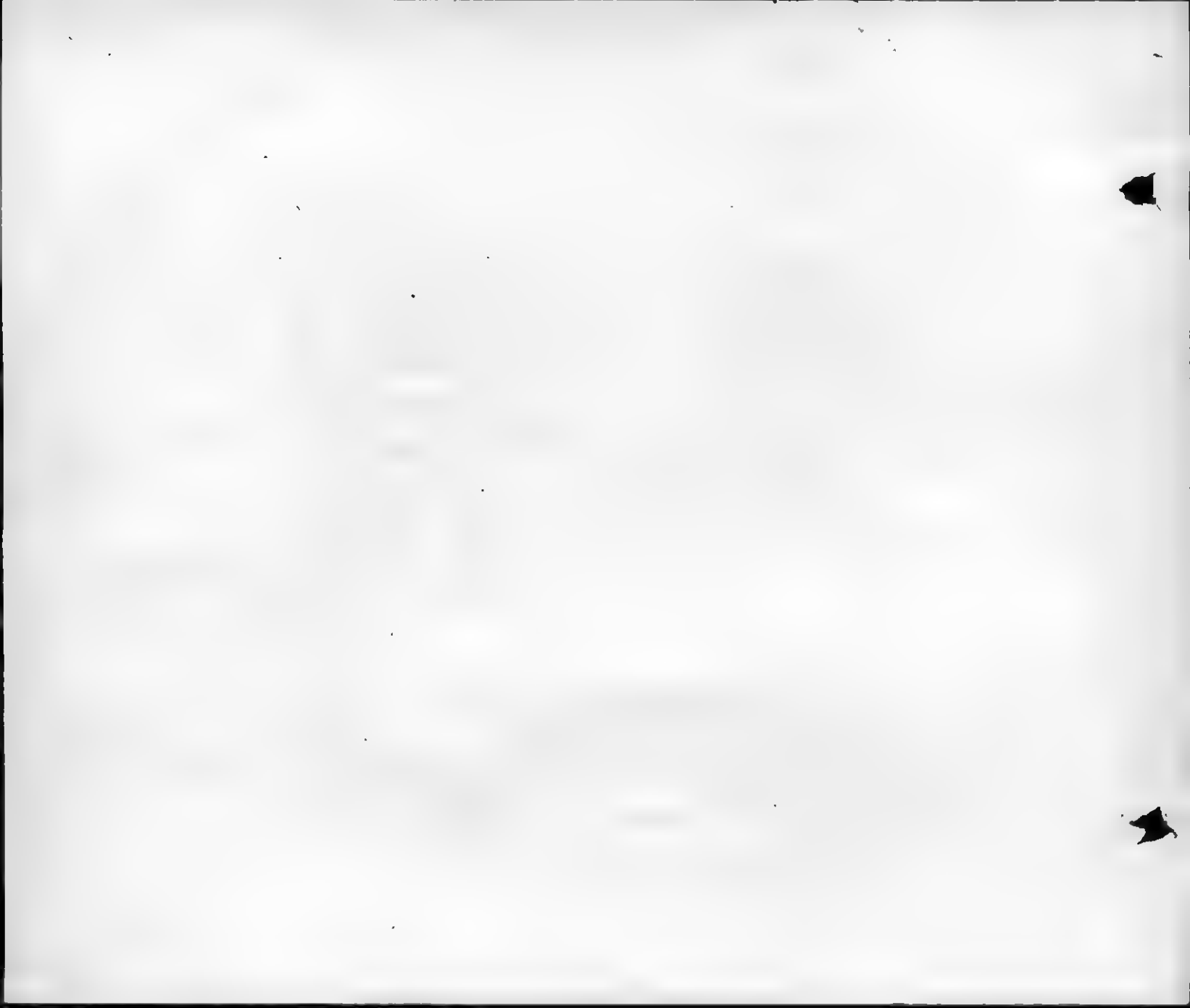
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				d. STREET ADDRESS 901 S.Division St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MATTIE Middle ELIZABETH Last STEVENS				4. DATE OF DEATH Month JAN. Day 1st Year 1961			
5. SEX Female EMX		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1902	
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 11 Hours Min. 		IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee (Restaurant)				10b. KIND OF BUSINESS OR INDUSTRY Pittsville, Maryland		11. BIRTHPLACE (State or foreign country) U S A	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME L. Teagle Truitt				14. MOTHER'S MAIDEN NAME Emma C. Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Mr. Everett Stevens (Husband)			
				17. INFORMANT Address 901 S.Division St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Destructive Pulmonary Emphysema INTERVAL BETWEEN ONSET AND DEATH 5+ yrs							
(b) Arteriosclerotic Heart Disease DUE TO 5+ yrs							
(c) mitral stenosis DUE TO (?)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma - Myocardial Infarction							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	
				20f. (City or town) N/A		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/10 19 61 to 1/1 19 61 , that (I) (we) last saw the deceased alive on 12/31 19 60 , and that death occurred at 9 AM , from the causes and on the date stated above.							
22a. SIGNATURE Dr. Rufus S. Gardner Jr.				22b. DATE SIGNED Jan. 3 / 1961			
22c. PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill				22d. ADDRESS Pine Bluff Road-Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 3, 1961		23c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery		23d. LOCATION (City, town, or county) (State) Bittsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		25a. REC'D BY REGISTRAR DATE JAN 5 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



1322
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1312

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY</u>			
				d. STREET ADDRESS <u>209 10TH STREET</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ETTA</u> Last <u>TAYLOR</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 1, 1878</u>		9. AGE (In years last birthday) <u>82</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN WATSON</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA STEWART</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. A. T. KELLY, 209 10TH STREET, POCOMOKE CITY, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus; Arterial Hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I of Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		
			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 20</u> , 19 <u>61</u> , to <u>Jan 25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 25</u> , 19 <u>61</u> , and that death occurred at <u>12 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Gilmore</u>				22b. DATE SIGNED <u>1-26-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>				22d. ADDRESS <u>SALISBURY, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-27-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NELSON CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>RURAL-POCOMOKE CITY MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>				25a. REC'D BY REGISTRAR <u>Pocomoke Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	
				DATE <u>JAN 30 '61</u>			



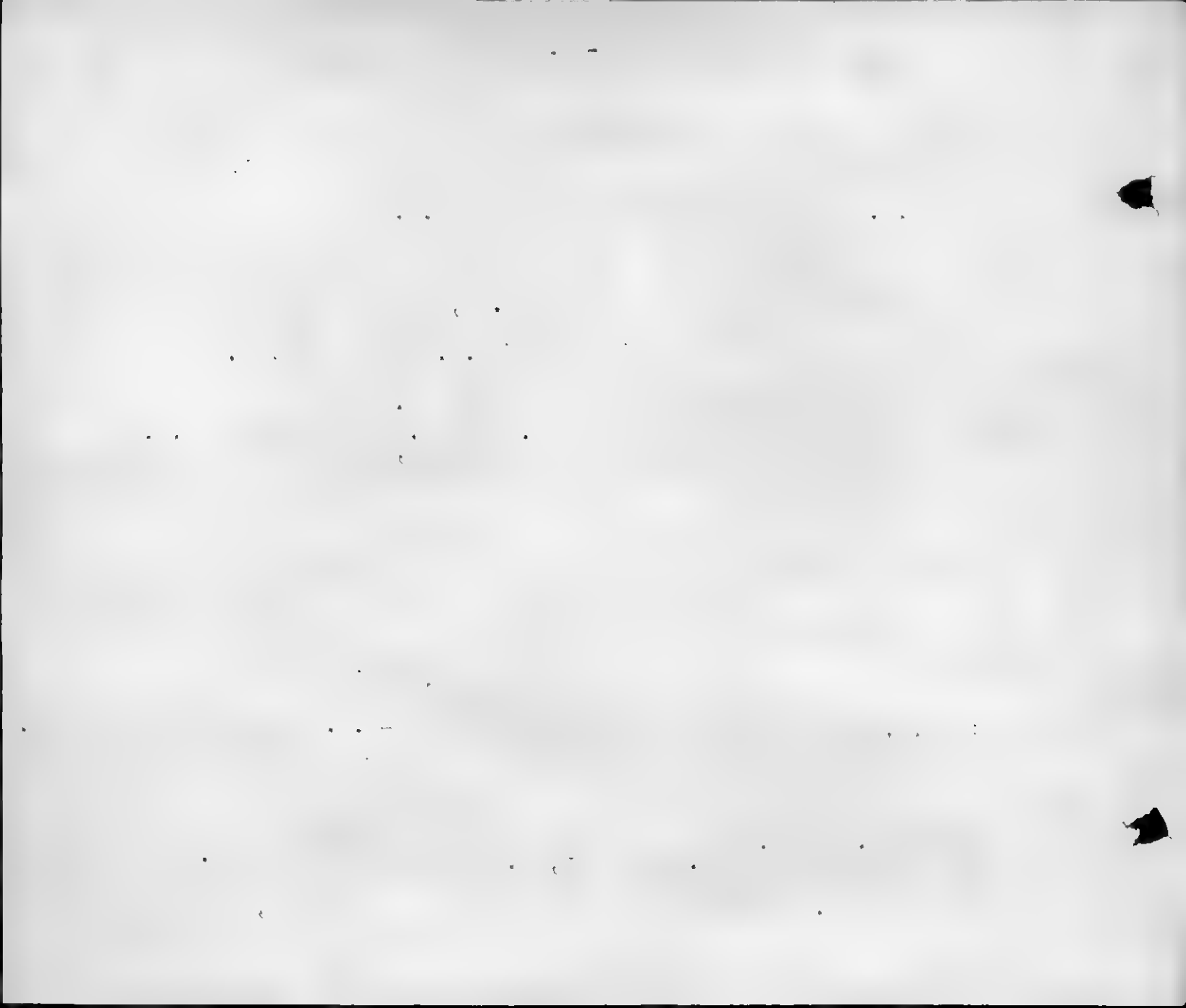
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deaths necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1328 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1313											
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury (Rural) c. LENGTH OF STAY IN IT MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D.# 1 (At Home on Farm)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury (Rural) d. STREET ADDRESS R.D.# 1					
3. NAME OF DECEASED (Type or print) WILLIAM EDWARD TOWNSEND						4. DATE OF DEATH Month JANUARY Day 2nd Year 1961					
5. SEX Male						6. COLOR OR RACE White					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH Nov. 1, 1900					
9. AGE (In years last birthday) 60 yrs.						10. IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Gulf Oil Co) on Route						10b. KIND OF BUSINESS OR INDUSTRY Driver-Salesman					
11. BIRTHPLACE (State or foreign country) R.D.# Salisbury, Md.						12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME Murray Edward Townsend						14. MOTHER'S MAIDEN NAME Alice A. Pusey					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No						16. SOCIAL SECURITY NO. Mrs. Mamie P. Townsend (Wife) R.D.# 1 Salisbury, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Cervical Spine DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) Fracture Cervical Spine DUE TO cause last (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING CAUSE OF DEATH						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Farm Tractor turned over, falling on driver					
20c. TIME OF INJURY Month, Day, Year 6:00 P.M. 1/2 1961						20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At Home on Farm						20f. (City or town) (County) (State) R.D.#1 Salisbury (Wico) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dr. Earl L. Royer						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED Jan. 3 /1961					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF Jan. /1961					
22c. NAME OF CEMETERY OR CREMATORY Fruitland Cemetery						22d. LOCATION (City, town, or country) (State) Fruitland, Maryland					
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY						ADDRESS SALISBURY MARYLAND					
24a. REC'D BY REGISTRAR JAN 5 '61						24b. REGISTRAR'S SIGNATURE Arthur L. Hanna					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1329 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission, if not) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>		c. LENGTH OF STAY IN IN <u>1</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Delmar Rd</u>		e. STREET ADDRESS <u>Delmar Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Cheryl Ann Tull</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-19-60</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		9b. AGE (In years last birthday) <u>2</u> yrs. <u>17</u> Months <u>1</u> Days <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Purnell Wodson</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Tull</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>112 Chestnut St. Salisbury</u>	
17. INFORMANT <u>Mildred Tull</u>		Address <u>112 Chestnut St. Salisbury</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> DUE TO (a), stating the underlying cause last, (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/13/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist</u>		22d. LOCATION (City, town, or country) (State) <u>Delmar Md.</u>	
23. FUNERAL DIRECTOR <u>Clinton S. Stewart</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Howard</u>	
ADDRESS <u>Salisbury, Md.</u>		DATE <u>JAN 12 '61</u>	

VS. A15ME
SM 759



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

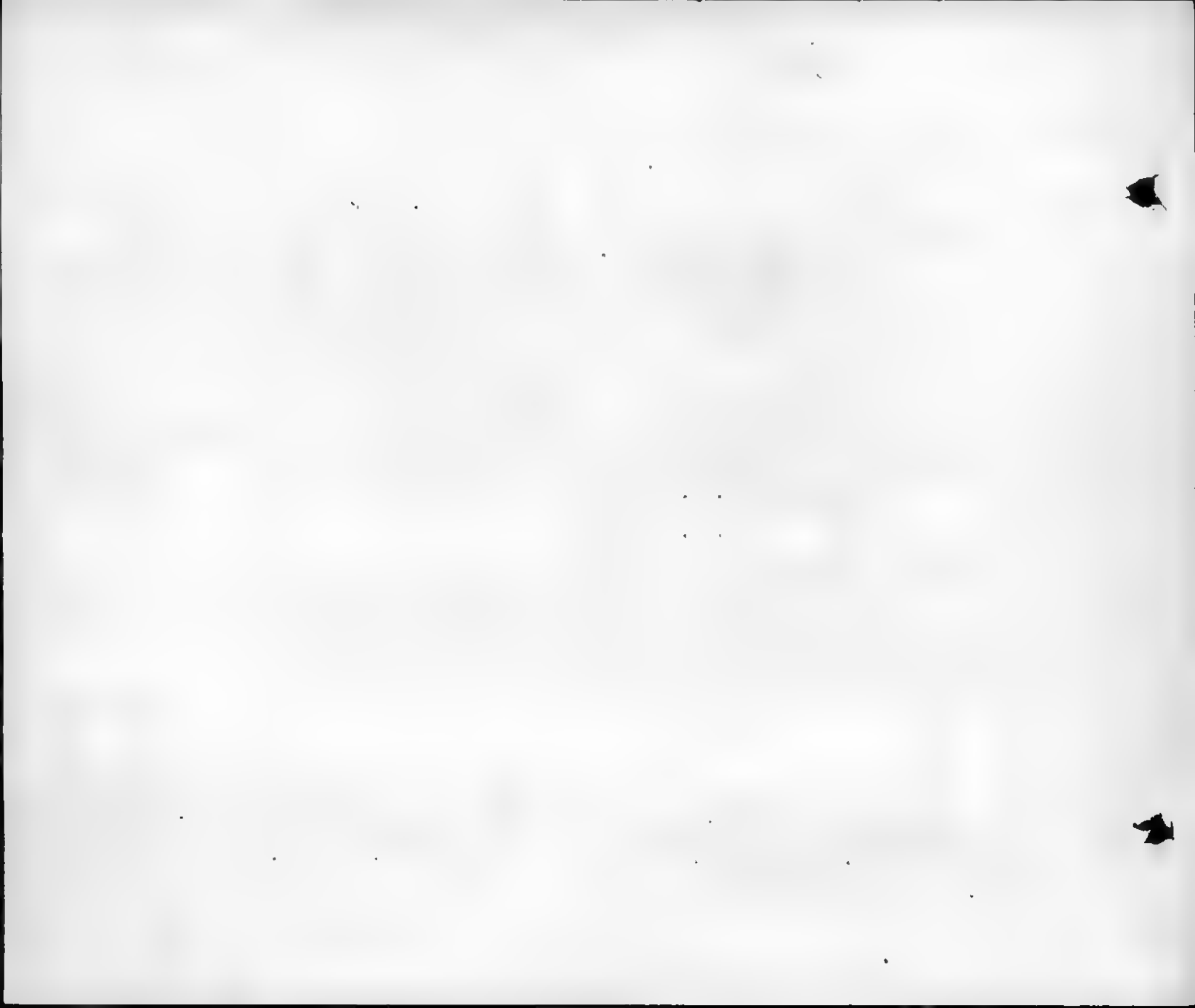
VR A15 (4)
15M 11/59

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1330

1315

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>Salisbury,</u> <u>MARYLAND</u>				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>4mo. 1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton, Maryland</u> <u>05x -2</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>210 S. 3rd. Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>W.</u> Last <u>Warren</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>22</u> Year <u>1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-18-85</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Warren</u>				14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. <u>217-28-1228</u>		17. INFORMANT <u>Hospital records</u>		Address <u>Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A. S. Heart Disease</u> <u>420.00</u> DUE TO <u>A. S. General</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 21</u> , 19 <u>60</u> , to <u>Jan 22</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 22</u> , 19 <u>61</u> , and that death occurred at <u>4:25 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>L. Maldve,</u>		M.D. <input type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Jan. 22, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. Maldve, M.D.</u>		22d. ADDRESS <u>Salisbury, Md.</u>					
23a. BURIAL, CREMATION, OR DISPOSITION (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 24, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bloomery</u>		23d. LOCATION (City, town, or county) (State) <u>Near Denton, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. ...</u>				25a. REC'D BY REGISTRAR <u>JAN 25 1961</u>		25b. REGISTRAR'S SIGNATURE <u>John G. ...</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

1331

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1316

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <u>Md</u> b. COUNTY <u>Somerset</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>Rural Princess Anne</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				d. STREET ADDRESS <u>19X</u>					
3. NAME OF DECEASED (Type or print) <u>Roger</u> First <u>Barton</u> Middle <u>White</u> Last				4. DATE OF DEATH <u>January 6</u> 19 <u>61</u> Month Day Year					
5. SEX <u>m</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1886</u>			
9. AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Well Driller</u>				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Daniel White</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Green</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO.					
17. INFORMANT <u>Mrs. Orra White</u> Address <u>Mt. Vernon, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 6</u> , 19 <u>61</u> , to <u>Jan 6</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 6</u> , 19 <u>61</u> , and that death occurred at <u>12</u> PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>1/6/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Prine Bluff Road, Salisbury, Md</u>				22d. ADDRESS					
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/8/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Episcopal</u>		23d. LOCATION (City, town, or county) (State) <u>Mt Vernon Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Hunn</u> ADDRESS <u>Princess Anne Md</u>				25a. REC'D BY REGISTRAR <u>JAN 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

1. *Chlorophyll *a** and *Chlorophyll *b** were determined by the method of Arar and Collins (1971) using a Shimadzu 1010 spectrophotometer.

1st of March 1884

1332

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01317

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wicomico Memorial Hospital</u>				d. STREET ADDRESS <u>1341 S. Division St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>STELLA LEE White</u>				4. DATE OF DEATH - <u>Jan 4</u> 19 <u>61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 28, 1891</u>		9. AGE (in years at birthday) <u>69</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Eden, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Dykes</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Shockley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mr. Martin White (Husband) 1341 S. Division St. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Origin undetermined (Microscopic examination may reveal & later</u> (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>N/A 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1959</u> to <u>Jan 4</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 4</u> 19 <u>61</u> , and that death occurred at <u>4</u> M. from the causes and on the date stated above							
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> <u>1/5/61</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Joseph C. Fitzgerald</u>				22d. ADDRESS <u>707 Camden Ave. Salisbury Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 7, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		25a. REC'D BY REGISTRAR <u>JAN 6 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

61318

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards		c. LENGTH OF STAY IN 1b Willards		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards		d. STREET ADDRESS New Hope Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Louis Preston Wilkens		4. DATE OF DEATH Month 1-2-61		Day 19		Year 19		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-27-1910		9. AGE (In years last birthday) 50		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Att.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry Wilkins		14. MOTHER'S MAIDEN NAME Manie Dishroon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) XX XXX		16. SOCIAL SECURITY NO. 220-26-3516		17. INFORMANT Lillian Carter Willards, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of brain DUE TO 9776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted single barrel shotgun wound of head.		20c. TIME OF INJURY Month, Day, Year 10 A.M. 1-2-61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Willards		20g. (County) Wicomico		20h. (State) Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Earl L. Royer		EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DATE SIGNED 1-3-61		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE OF BURIAL, CREMATION, OR REMOVAL Jan. 4, 1961		22c. NAME OF CEMETERY OR CREMATORY New Hope		22d. LOCATION (City, town, or country) (State) Willards									
23. FUNERAL DIRECTOR Peter Whaley		24a. REC'D BY REGISTRAR 1-9-61		24b. REGISTRAR'S SIGNATURE 1-9-61		24c. REGISTRAR'S NAME 1-9-61		24d. REGISTRAR'S ADDRESS 1-9-61		24e. REGISTRAR'S PHONE 1-9-61		24f. REGISTRAR'S CITY 1-9-61		24g. REGISTRAR'S STATE 1-9-61									

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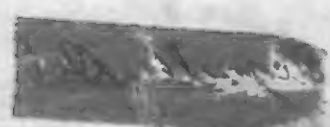
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1334

CERTIFICATE OF DEATH

1319

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 13 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tony Tank Rd.,				d. STREET ADDRESS Tony Tank Rd.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle FRANKLYN Last WOODCOCK				4. DATE OF DEATH Month 1 Day 18 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1891	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate				10b. KIND OF BUSINESS OR INDUSTRY Broker		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel P. Woodcock				14. MOTHER'S MAIDEN NAME Carrie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. S.F. Woodcock, Same	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Occlusion, Acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic Heart Disease (c) Myocardial insufficiency, Chronic							INTERVAL BETWEEN ONSET AND DEATH 1 day 3+ yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/24 1957 to 1/18 1961 , that (I) (we) last saw the deceased alive on 1/17 1961 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Rufus S. Gardner Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-20-1961	
22c. PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner				22d. ADDRESS Pine Bluff Rd., Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/20/1961		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill & Johnson Co. Salisbury, Maryland				25a. REC'D BY REGISTRAR DATE JAN 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

